The World Breastfeeding Trends Initiative (WBT*i*)

ARE OUR BABIES OFF TO A HEALTHY START?

The State of Implementation of the *Global Strategy for Infant and Young Child Feeding* in 18 European Countries

IBFAN
defending breastfeeding

WBTi
World Breastfeeding Trends Initiative (WBT*i*)

The World Breastfeeding Trends Initiative (WBT*i*)
WBT*i* European Working Group

ARE OUR BABIES OFF TO A HEALTHY START?

The State of Implementation of the *Global Strategy for Infant and Young Child Feeding* in 18 European Countries

Published by:

UNIVERSITY OF SPLIT SCHOOL OF MEDICINE

Supported by:

Ministry of Health

unicef for every child

2020

ARE OUR BABIES OFF TO A HEALTHY START?

January 2020

Suggested citation: The World Breastfeeding Trends Initiative (WBT*i*). Are our babies off to a healthy start? The state of implementation of the Global Strategy for Infant and Young Child Feeding in 18 European countries. University of Split School of Medicine, Split, Croatia, 2020

REPORT WRITING AND PRODUCTION

WBT*i* European working group: Irena Zakarija-Grković, Adriano Cattaneo, Maria Enrica Bettinelli, Claudia Pilato, Charlene Vassallo, Mariella Borg Buontempo, Helen Gray, Clare Meynell, Patricia Wise, Susanna Harutyunyan, Stefanie Rosin, Andrea Hemmelmayr, Daiva Šniukaitė-Adner, Maryse Arendt, Arun Gupta.

Reviewed by:
Joao Breda / WHO European Office for Prevention and Control of Noncommunicable Diseases
Bente Mikkelsen / Division of Noncommunicable Diseases and Health Promotion through the Life-course

Design & Layout: Dijana Kasavica / UNICEF Office for Croatia

Front cover image of breastfeeding mother: Paul Carter / wdiip.co.uk

PUBLISHED BY
University of Split School of Medicine; Šoltanska 2, 21000 Split, Croatia

PRINTED BY
DES Institution for employment, labour and professional rehabilitation of persons with disabilities

Circulation: 1000 copies

CIP - Katalogizacija u publikaciji
S V E U Č I L I Š N A K N J I Ž N I C A U S P L I T U

UDK 613.953(4)"20"
618.63(4)"20"
614(4)"20"

THE World Breastfeeding Trends Initiative (Delhi)
Are our babies off to a healthy start?: the state of implementation of the Global strategy for infant and young child in 18 European countries / The World Breastfeeding Trends Initiative (WBT*i*);
<WBT*i* European working group Irena Zakarija-Grković ...>. - Split: University, School of Medicine, 2020.

ISBN 978-953-7524-27-2

I. Prehrana -- Djeca -- Zdravstveno gledište II. Dojenčad -- Zdravlje i higijena -- Priručnici
III. Promicanje dojenja -- Europa -- 21. st. IV. Europa -- Javno zdravstvo

171104038

Contents

Photo by Paul Carter / wdlip.co.uk

Acknowledgements

This report was inspired by the original 'Are our babies falling through the gaps?' document, published in 2012 by Breastfeeding Promotion Network India (BPNI) and International Baby Food Action Network (IBFAN) Asia, in which the state of implementation of the *Global Strategy for Infant and Young Child Feeding* in 51 non-European countries is detailed, using the World Breastfeeding Trends Initiative (WBT*i*) tool.

This initiative would not have gained momentum if it were not for the Swedish International Development Agency (SIDA) and the Norwegian Agency for Development Cooperation (NORAD), who have been supporting the WBT*i* since its inception. Without their support, the training of 31 representatives from 23 European countries would not have taken place. This was held in the form of three 3-day workshops, organised by BPNI/IBFAN between 2015 and 2017, resulting in the publication of 18 country reports thus far.

For each country report a country coordinator was required to form a core group and, together with relevant partners, produce a detailed account of the state of infant and young child feeding in their country. We, therefore, thank all those involved in producing the individual WBT*i* reports, for without their dedication and effort, we would not be able to obtain an objective overview of the situation in Europe.

Finally, all credit goes to Dr. Arun Gupta, Dr Shoba Suri and their team at BPNI and IBFAN Asia, without whom there would be no WBT*i*, for it was their 'brain child' that they have lovingly nurtured, giving selflessly of their time and expertise to see the implementation of the *Global Strategy for Infant and Young Child Feeding* strengthened worldwide, for the wellbeing of humankind.

Dr. Irena Zakarija-Grković,
MD, FRACGP, IBCLC, PhD
Coordinator, European Regional WBT*i* Report
WBT*i* Coordinator for Croatia

Acronyms

ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BHIVA	British HIV Association
BPNI	Breastfeeding Promotion Network of India
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CDC	Centre for Disease Control and Prevention
EACS	European AIDS Clinical Society
EBF	Exclusive breastfeeding
Global Strategy	Global Strategy for Infant and Young Child Feeding
IBFAN	International Baby Food Action Network
ILO	International Labour Organisation
IYCF	Infant and Young Child Feeding
NBC	National Breastfeeding Committee
OG-IFE	Operational Guidance on Infant Feeding in Emergencies
UNICEF	United Nations Children's Fund
WABA	World Alliance for Breastfeeding Action
WBT*i*	World Breastfeeding Trends Initiative
WHA	World Health Assembly
WHO	World Health Organisation

Country / abbreviations

Armenia / **AM**

Austria / **AT**

Belgium / **BE**

Bosnia and Herzegovina / **BA**

Croatia / **HR**

France / **FR**

Georgia / **GE**

Germany / **DE**

Italy / **IT**

Lithuania / **LT**

North Macedonia / **MK**

Moldova / **MD**

Malta / **MT**

Portugal / **PT**

Spain / **ES**

Turkey / **TR**

Ukraine / **UA**

United Kingdom / **UK**

Coordinators

WBT*i* Country Coordinators who participated in writing the European report:			
Country	**Coordinator**	**Contribution**	**Email**
AM	Susanna Harutyunyan	Indicators 11, 12	harsusanna@gmail.com
AT	Andrea Hemmelmayr	Indicators 7, 14	a.hemmelmayr@gmx.at
HR	Irena Zakarija-Grković	Coordinator, editor, Executive summary	irena.zakarija-grkovic@mefst.hr
DE	Stefanie Rosin	Indicator 2	stefanie.rosin@gmx.de
IT	Maria Enrica Bettinelli Adriano Cattaneo Claudia Pilato	Indicator 1, 4, 6, 10	mebettinelli@gmail.com adriano.cattaneo@gmail.com clapilato@gmail.com
LT	Daiva Sniukaite	Indicator 13, 15	daiva.sniukaite@gmail.com
MT	Mariella Borg Buontempo Charlene Vassallo	Indicator 8, 9	mariella.borg-buontempo@gov.mt charlene.b.vassallo@gov.mt
UK	Helen Gray Clare Meynell	Indicator 3, 5*	helengray123@yahoo.co.uk clarelmeynell@gmail.com

* written by Patricia Wise, WBT*i* Steering Group member

WBT*i* European Country Coordinators who have produced a national report (available at http://worldbreastfeedingtrends.org/country-report-wbti/):			
No.	**Country/Year Report Published**	**WBT*i* Country Coordinator**	**Email**
1.	AM/2015	Susanna Harutyunyan	harsusanna@gmail.com
2.	AT/2018	Andrea Hemmelmayr	a.hemmelmayr@gmx.at
3.	BE/2015	Els Flies	secretariaat@vbbb.bew
4.	BA/2015	Aida Filipovic	ahadziomeragic@hotmail.com
5.	HR/2015	Irena Zakarija-Grković	irena.zakarija-grkovic@mefst.hr
6.	FR/2017	Britta Boutry-Stadelmann	bst.boutry@wanadoo.fr
7.	GE/2015	Keteven Nemsadze	ketinemsadze@gmail.com
8.	DE/2018	Stefanie Rosin	stefanie.rosin@gmx.de
9.	IT/2018	Maria Enrica Bettinelli	mebettinelli@gmail.com
10.	LT/2017	Daiva Sniukaite	daiva.sniukaite@gmail.com
11.	MK/2017	Biljana Ancevska	ancevskabiljana@yahoo.com
12.	MT/2018	Charlene Vassallo Mariella Borg Buontempo	charlene.b.vassallo@gov.mt mariella.borg-buontempo@gov.mt
13.	MD/2017	Ala Curteanu	alacurteanu@yahoo.com
14.	PT/2015	Jacqueline de Montaigne	jdemontaigne@ibfanportugal.org
15.	ES/2018	Salomé Laredo	salome.laredo@uv.es
16.	TR/2015	Charlotte Cordon	lalecheleague.antalya@gmail.com
17.	UA/2015	Olga Schlemkevch	oshlem@rambler.ru
18.	UK/2016	Helen Gray Clare Meynell	helengray123@yahoo.co.uk

Photo by Claudia Pilato

Foreword

Nutrition is key to achieving the Sustainable Development Goals related to health, education, sustainable development, reduction of inequalities and more. Commitments to reduce health inequalities and improve maternal, infant and young child health have been made by the Member States and their national governments in a series of political documents at both regional and global levels. In Europe, Member States have demonstrated their commitment to promoting healthy nutrition according to the measures outlined in the WHO European Food and Nutrition Action Plan. The report of the Commission on Ending Childhood Obesity underlines how important it is for the WHO European Region to review current practices and promote policies and actions to improve maternal, infant, and young child nutrition across the region.

A major determinant of a child's immediate and future nutritional status and healthy growth and development comes from early nutrition, and exposure to appropriate infant and young child feeding practices. Breastfeeding is known to protect against obesity and noncommunicable diseases, which pose the greatest disease burden in the region. Unfortunately, despite WHO recommendations that children be breastfed exclusively for the first six months of life, only about 25% of infants are exclusively breastfed. Furthermore, as recent WHO European reports have shown, many baby foods have unacceptably high levels of sugar and are inappropriately marketed as suitable for infants under the age of 6 months. Many products also have statements on composition, nutrition, or health claims which can mislead parents, undermine breastfeeding and lead to unhealthy diets at a crucial time in life.

In order to guide future action and empower countries to learn with and from each other, it is important to identify gaps between policy recommendations and their effective implementation. This report provides a relevant and timely analysis of the progress that has been made concerning the implementation of the Global Strategy for infant and young child feeding in 18 European countries. Progress is being made, but much work also remains to be done.

The commitments made by Member States to promote healthy nutrition early in life can be achieved if we continue to invest in measures to improve breastfeeding rates and improve infant and young child feeding practices. Coordinated action is needed by governments to regulate and monitor the marketing of all commercial baby foods, through the implementation of the International Code of Marketing of Breast-milk Substitutes, as well as following the recent Guidance on ending the inappropriate promotion of foods for infants and young children. Efforts must also be made to protect, promote and support breastfeeding in health facilities globally.

These key goals require resource-related commitments, as well as policies and regulations to support breastfeeding mothers, protect consumers from being misled, and promote appropriate infant feeding. Such investments will help reduce health inequalities and help accelerate progress toward achieving Sustainable Development Goals.

Joao Breda, Head
WHO European Office for Prevention and Control of Noncommunicable Diseases, Moscow

Bente Mikkelsen, Director
Division of Noncommunicable Diseases and Health Promotion through the Life-course, Copenhagen

Preface

In 2003-4, WHO developed and launched tools for national assessment of infant and young child feeding policies and programmes. I began thinking how this tool could be introduced in all countries, how it could be made simpler and easier to understand, and how it could be used to generate local action. One of the things that crossed my mind was how to make the results of using this tool universally accessible. I, along with our team at Breastfeeding Promotion Network of India (BPNI), used the WHO questionnaire and adapted it based on lessons learnt from Africa and Asia where the WHO tool was tested. I worked with Anubhav Kushwaha, an IT student, who helped me carve out the first version of a web-based tool. The web-based tool was designed with an idea to provide an objective score and colour coding for the ten policy and programme indicators as well as five practice indicators. Its objective was to assess a country's policy and programmes through simple research and to use the findings to call for change. It was titled 'The Asia Pacific Participatory Action Research' (APPAR) and built as a tracking, assessment and monitoring (TAM) tool. One of the inherent parts of the tool was to encourage reassessment after 3-5 years.

With our small team, we added 'action' to the assessment, i.e. how to use the findings of the assessment to make a 'Call to action' at a national level. It was first introduced at the 'South Asia Breastfeeding Partners' Forum' in Bangladesh in 2004, as a tool for South Asian (SA) countries. Eight SA countries used it and found it to be useful for bridging gaps found in policy/programmes. One official from the Ministry of Health from Bhutan commented, "*It's an eye opener*". With success in hand, and thinking how to make it global, we re-branded it as the World Breastfeeding Trends Initiative (WBT*i*). We launched WBT*i* in other regions of the world, through the International Baby Food Action Network (IBFAN), making it global in 2008/9. The WBT*i* was launched in Europe in 2015 and eighteen countries have so far completed their assessment and published a report.

Since its implementation, several global and regional WBT*i* reports have been published.[1] In 2011, news of the WBT*i* was announced in the BMJ, when the 33-country WBT*i* report was launched.[2] The WBT*i* has been accepted globally as a credible source of information on IYCF polices and programmes by the WHO's National Implementation of BFHI 2017,[3] and Operational Guidance on Infant Feeding in Emergencies, 2017,[4]. The Global Breastfeeding Collective (GBC) and the Global database on the Implementation of Nutrition Action (GINA) also recognise WBT*i* as a resource.[5]

1 http://worldbreastfeedingtrends.org/documents-paper/

2 Mayor S. More than half of infants in developing countries are breast fed for less than six months, report says. BMJ 2011;342:d18

3 https://www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/

4 https://www.ennonline.net/attachments/3028/Ops-Guidance-on-IFE_v3-2018_English.pdf

5 https://extranet.who.int/nutrition/gina/

The GBC is a joint initiative by UNICEF & WHO to accelerate progress towards achieving the WHA target of exclusive breastfeeding to 50% by 2030. The Global Breastfeeding Scorecard for tracking progress for breastfeeding policies and programmes, developed by the Collective, has identified a target that at least three-quarters of the world's countries should conduct a WBT*i* assessment every five years by 2030.[6]

The methodology of WBT*i* is the key for generating action and keeping it free from conflicts of interest; WBT*i* guidance to form a conflict of interest-free core group at country level is emphasized. This core group gathers information on various indicators and then organises discussions with relevant partner organisations on findings, gaps and recommendations in order to build consensus at national level. Once these are verified, findings are published on the WBT*i* web portal. At present, worldwide, 97 countries have done the WBT*i* assessment and reporting. Moreover, during this period 35 countries repeated their assessments and used it for continued advocacy efforts. Twenty-nine countries have improved in scores for policy and programmes. Overall, countries have gained 14 points on average (from 50.1 to 64.4) ranging from 16.5 to 53 points. What does this mean? It means improved policies and programmes such as the Code, maternity protection, infant feeding during disasters and improved hospital practices. Afghanistan, Bangladesh, Dominican Republic and Indonesia even managed to double their scores.[7]

"ARE OUR BABIES OFF TO A HEALTHY START? The State of Implementation of the *Global Strategy for Infant and Young Child Feeding* in 18 European Countries is an analytical report from the European region that shows gaps and achievements in policy and programmes in these countries. The report throws light on worrying data on breastfeeding practices and seeks to draw the attention of national and European politicians/ policy makers to substandard policies, calling for strategic investment of resources. It calls upon all countries to join this effort.

The report highlights gaps and achievements in 15 areas of action within the framework of the *Global Strategy*. It provides key recommendations for each of the policy/programme areas. It goes into the micro details of each indicator and showcases specific gaps at country level. A range of experts in child health, nutrition, public health and lactation have produced the report, suggesting the need for corrective action in all areas to ensure structural support for women to remove barriers to breastfeeding.

The report will make a useful addition to the ongoing efforts in the region to increase rates of breastfeeding and improve infant and young child feeding practices. Every country would need to take concrete steps to bridge the gaps. Immediate steps could be the development of a concrete plan and assuring resources. Hopefully, the report will also generate interest among countries towards fulfilling the World Health Assembly targets on nutrition, including breastfeeding, by 2025.

Dr. Arun Gupta MD (paed)
Central Coordinator of Breastfeeding Promotion Network of India (BPNI)
Global Coordinator, World Breastfeeding Trends Initiative (WBT*i*)

6 https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2017.pdf?ua=1

7 Gupta A, Suri S, Dadhich JP et al. The World Breastfeeding Trends Initiative: Implementation of the Global Strategy for Infant and Young Child Feeding in 84 countries. J Public Health Pol 2019;40:35-65

Executive summary

BACKGROUND

In 2002, the *Global Strategy for Infant and Young Child Feeding (Global Strategy)* was presented to and endorsed by all countries of the Fifty-fifth World Health Assembly (WHA), the world's highest health policy-setting body, including 53 countries from the European Region. This seminal document was jointly developed by WHO and UNICEF, using an evidence-based approach, to ″revitalize world attention to the impact that feeding practices have on the nutritional status, growth and development, health and thus the very survival of infants and young children″. The *Global Strategy* is intended as a 'guide for action', calling upon governments, international organisations and other concerned parties to move swiftly and deliberately in implementing optimal infant and young child feeding (IYCF) policies, programmes and practices, using an integrated, comprehensive approach. These actions include: 1) establishing a multisectoral national breastfeeding committee, headed by a national breastfeeding coordinator; 2) ensuring that every maternity facility fully implements the Baby-friendly Hospital Initiative; 3) expanding the Initiative to include clinics, health centres and paediatric wards; 4) upholding the International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions in their entirety; 5) protecting the breastfeeding rights of working women and establishing means for its enforcement; 6) establishing an efficient system for regular monitoring of feeding practices using standardised WHO infant feeding definitions; 7) developing, implementing, monitoring and evaluating a comprehensive policy on IYCF; 8) protecting, promoting and supporting exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women with the support they require to achieve this goal; 9) promoting timely, adequate, safe and appropriate complementary feeding; 10) providing guidance on IYCF in exceptionally difficult circumstances, e.g. natural catastrophes or in the setting of HIV; 11) ensuring that all who are responsible for communicating with the general public provide accurate and complete information on IYCF; 12) ensuring skilled counselling is provided to mothers by training health workers and revising pre-service curricula; and 13) enabling hospitalised mothers/children, where feasible, to stay together to ensure continued breastfeeding.

To monitor the implementation of the *Global Strategy*, WHO developed a tool, in 2003, for assessing national practices, policies and programmes. This tool was adapted by Dr Arun Gupta and his team, at the Breastfeeding Promotion Network of India (BPNI), based on lessons learnt from Africa and Asia, where the WHO tool was tested. In order to make the tool universally accessible, a web-based version was designed providing an objective score and colour coding for ten policy and programme indicators as well as five practice indicators covered by the *Global Strategy*. Its objective was to monitor the status and progress of *Global Strategy* implementation worldwide through simple research, and to use the findings to call for change. One of the inherent parts of the tool was to encourage reassessment after 3-5 years to monitor trends in IYCF. It was titled 'The Asia Pacific Participatory Action Research' (APPAR) and was first presented at the Asia Pacific Conference on Breastfeeding, in New Delhi, India, in December 2003. Eight South Asian countries took up the challenge and used the tool to assess national IYCF policies, programmes and practices. In 2004, BPNI launched the tool in Bangladesh during the South Asia Forum of Breastfeeding Partners. In 2008, the tool was re-branded as the *World Breastfeeding Trends Initiative* (WBT*i*) and launched globally through the International Baby Food Action Network (IBFAN). By 2010, 33 countries had become involved in WBT*i*, whereas by 2012, 51 countries had conducted a WBT*i* assessment, the findings of which are summarised in the IBFAN/BPNI document 'ARE OUR BABIES FALLING THROUGH THE GAPS?'. Of note is that none of the 51 countries were from the European Region; hence, with the support of the Swedish International Development Agency (SIDA) and the Norwegian Agency for Development Cooperation (NORAD), between 2015, when

the WBT*i* was launched in Europe, and 2017, 31 representatives from 23 European countries were trained in conducting a WBT*i* assessment. So far, eighteen European countries have completed their assessment and published the reports, which are available on the WBT*i* website. They are: Armenia, Austria, Belgium, Bosnia and Herzegovina, Croatia, France, Georgia, Germany, Italy Lithuania, North Macedonia, Moldova, Malta, Portugal, Spain, Turkey, Ukraine and the United Kingdom. This document, titled 'ARE OUR BABIES OFF TO A HEALTHY START?', represents a summary of the 18 published European reports.

The aims of this report are to:

1) Draw the attention of national and European politicians/policy makers to the importance of optimal IYCF;
2) Raise awareness among national and European politicians/policy makers of sub-standard IYCF policies, programmes and practices in Europe;
3) Highlight gaps in IYCF policies, programmes and practices, so that national and European politicians/policy makers know where to invest resources;
4) Provide recommendations, based on best practices in Europe, on how IYCF policies and programmes can be strengthened to improve practices;
5) Motivate all countries in the European region to take part in WBT*i* and repeat the evaluation every 3 - 5 years.

METHODS

The WBT*i* has 15 indicators: ten linked to policies and programmes and five to infant feeding practices (Table 1). Each indicator used for individual country assessment has the following components: **Background** on why the practice, policy or programme component is important, **Key question** that needs to be investigated, a list of **Key criteria** to be used for assessment, possible **Sources of Information**, **Gaps** identified, agreed **Recommendations** and **Conclusions**. The findings are scored and colour-rated to clearly indicate where the country stands. Each indicator is scored on a scale of 10; thus, the maximum score for 'policy and programmes' is 100, and 50 for 'infant feeding practices', giving a total score of 150 on *Global Strategy* implementation (Table 2).
The process of conducting a WBT*i* assessment consists of each country selecting a 'national WBT*i* coordinator' who forms a core group of approx. 4-5 people, representing government, professional and relevant non-governmental organisations, **without conflicts of interest**. The WBT*i* Guide Book provides an overview of the WBT*i* process, and is a good starting point for national team members. Thorough assessment of individual indicators is conducted by core group members using the WBT*i* Assessment Tool. Assessment is based on available national data (policies, documents, official websites, survey findings, professional guidelines...) and/or on interviews with key government officials, as outlined in the WBT*i* 'Possible Sources of Information' document. Once scoring of indicators, identified gaps and recommendations are agreed upon, a preliminary report, based on the WBT*i* Report Template, is forwarded to a wider audience of partners for comments and consensus. A final report, with incorporated suggestions, is sent to the Global WBT*i* Secretariat for review and validation. This is then fed into the WBT*i* Web-Based Toolkit© which objectively quantifies the data to provide a colour-coded rating in Red, Yellow, Blue or Green, in ascending order of performance (Table 2). Once finalised, the Report and accompanying summary Report Card are published on the WBT*i* website, and findings are shared with a wider audience, including government officials and professional organisations, via a 'Call to Action'. Re-assessment is conducted every 3-5 years to track trends on the various indicators, assess progress and study the impact of any particular intervention (Figure 1).

In May 2018, the WBT*i* was presented at the European Lactation Consultants Alliance Conference, held in Rotterdam, The Netherlands. This provided the opportunity for interested and involved individuals to get together and share experiences on WBT*i* implementation, which led to the formation of an email group of European WBT*i* coordinators. Inspired by the document 'ARE OUR BABIES FALLING THROUGH THE GAPS?', and with the approval of the document's author, a core group of European coordinators decided to produce a similar report on the state of implementation of the *Global Strategy* in Europe. In June 2018, core group members were invited by the designated coordinator to choose Indicators for reporting and to adhere to the format used in the earlier document. Between June and October 2018, each

core group member carefully read all 18 published WBT*i* European reports for their chosen indicator/s and presented the findings under the following headings: **Background**, **Key Question**, **Criteria for Assessment**, **Findings** and **Detailed Findings**. Findings are depicted using colour-coded tables to aid interpretation. In addition, **Key Findings**, **Key Recommendations** and **Best Practices** are highlighted in the report. The 'Best Practice' scenarios, new to this report, represent real-world examples of what European countries have done to improve *Global Strategy* implementation. They endeavour to highlight how the highest ranking countries for each indicator achieved their top scores, in the hope that they will serve as an example and inspiration to others. Between October 2018 and May 2019, several iterations of the Report were produced, involving contacting national WBT*i* teams for clarification of findings, standardising reporting format and achieving consensus on Report content.

RESULTS

Overall implementation of the Global Strategy in the WHO European Region

This section presents an overview of where the 18 countries that completed and published a WBT*i* report between 2015 and 2018 stand in regard to implementation of the *Global Strategy*.

Figure 2 shows the scores and colour coding for the WBT*i* Policy, Programme and Practices indicators. Figure 3 shows the overall scores with the overall colour codes. The top five ranking countries are **Turkey, Croatia, Ukraine, Portugal and Georgia**; the five countries with the lowest overall score are Austria, Germany, Lithuania, Belgium and Spain. No countries are in the ″green zone″ for either policies

Table 1: **WBT*i* indicators**

Part I: policy and programmes (Indicator 1-10)	Part II: infant feeding practices (Indicator 11-15)
1. National Policy, Programme and Coordination	11. Early Initiation of Breastfeeding
2. Baby-friendly Hospital Initiative	12. Exclusive Breastfeeding
3. Implementation of the International Code of Marketing of Breastmilk Substitutes	13. Median Duration of Breastfeeding
4. Maternity Protection	14. Bottle Feeding
5. Health and Nutrition Care Systems	15. Complementary Feeding
6. Mother Support and Community Outreach	
7. Information Support	
8. Infant Feeding and HIV	
9. Infant Feeding During Emergencies	
10. Monitoring and Evaluation	

Table 2:

Colour coding for WBT*i* indicators

(maximum overall score: 150)

Indicators 1-10		Indicators 11-15		Indicators 1-15	
Scores	Colour-coding	Scores	Colour-coding	Scores	Colour-coding
0 – 30.9	RED	0 – 15	RED	0 – 45.5	RED
31 – 60.9	YELLOW	16 – 30	YELLOW	46 – 90.5	YELLOW
61 – 90.9	BLUE	31 – 46	BLUE	91 – 135.5	BLUE
91 – 100	GREEN	46 – 50	GREEN	136 – 150	GREEN

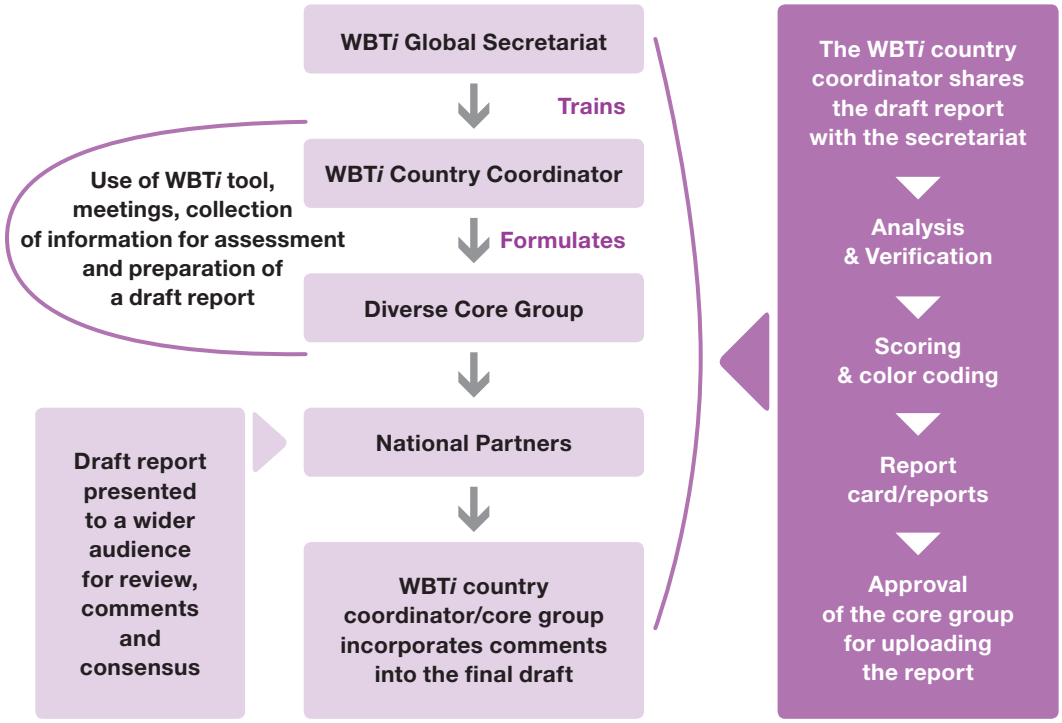


Figure 1:

WBT*i* Assessment Process

(Source: The WBT*i* Guide Book (2018))

The WBT*i* steps/processes

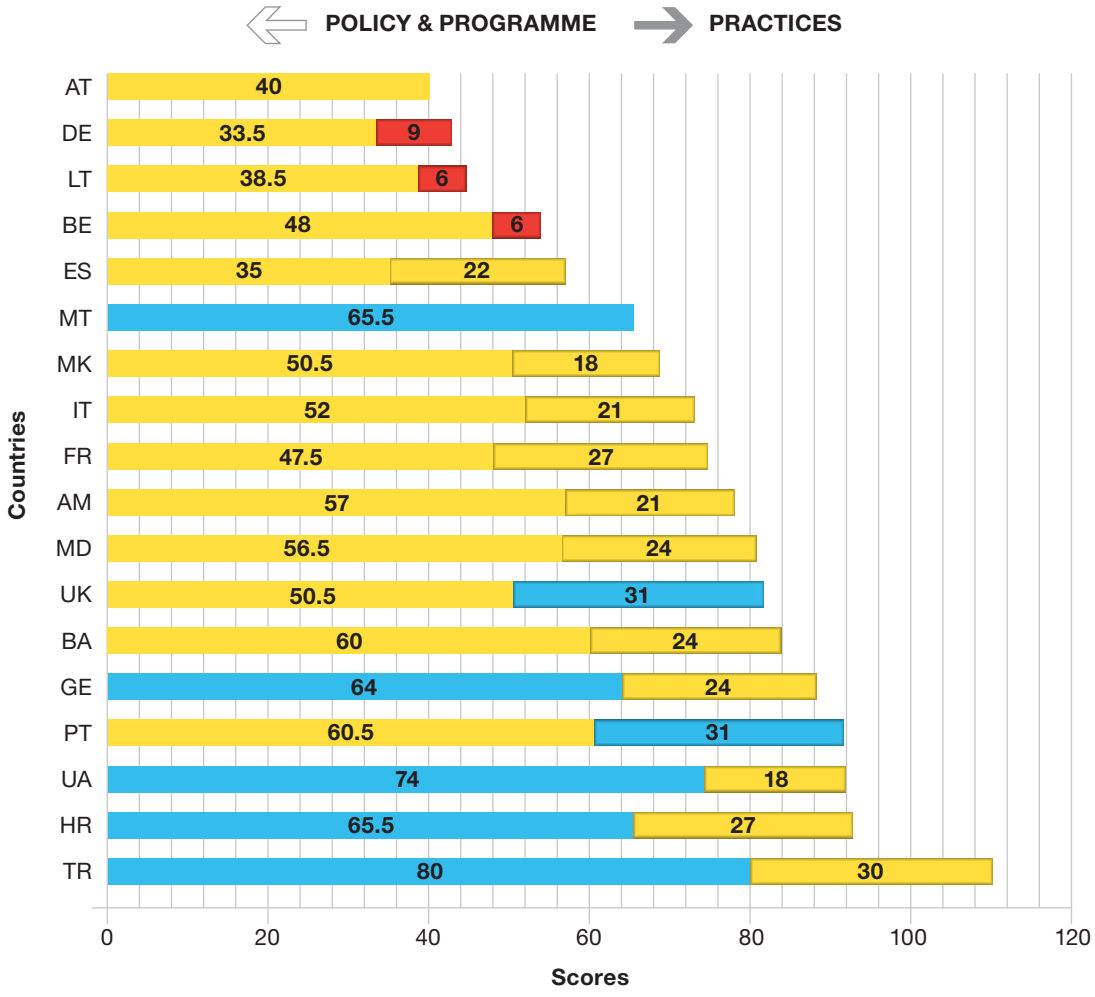


Figure 2:

The bars show the total scores for Policy & Programme indicators on the left and for Practice indicators on the right.

Figure 3:

WBT*i* overall score (Policy and Programme plus Practice indicators), out of a total of 150, in the 18 countries, with respective colour codes.

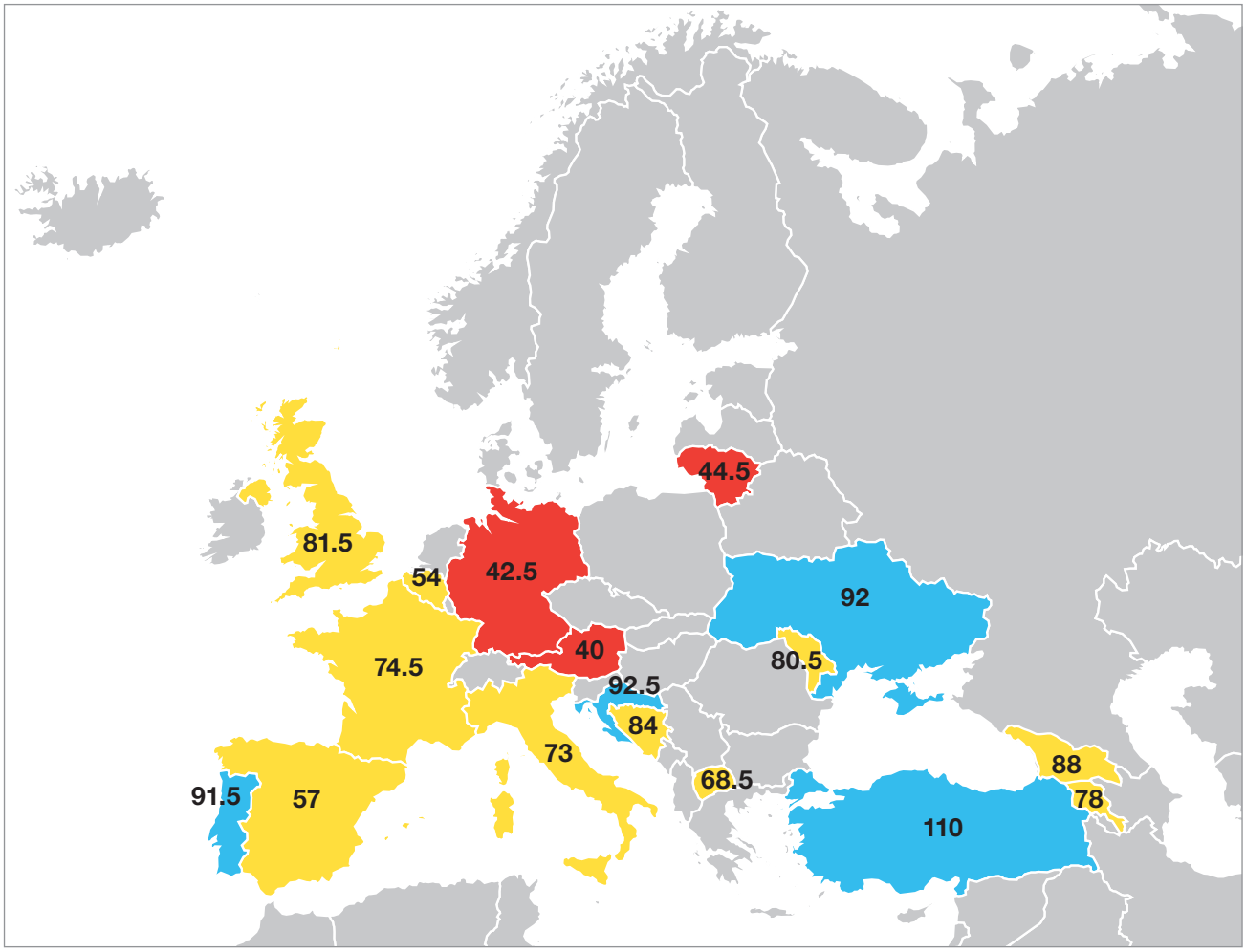
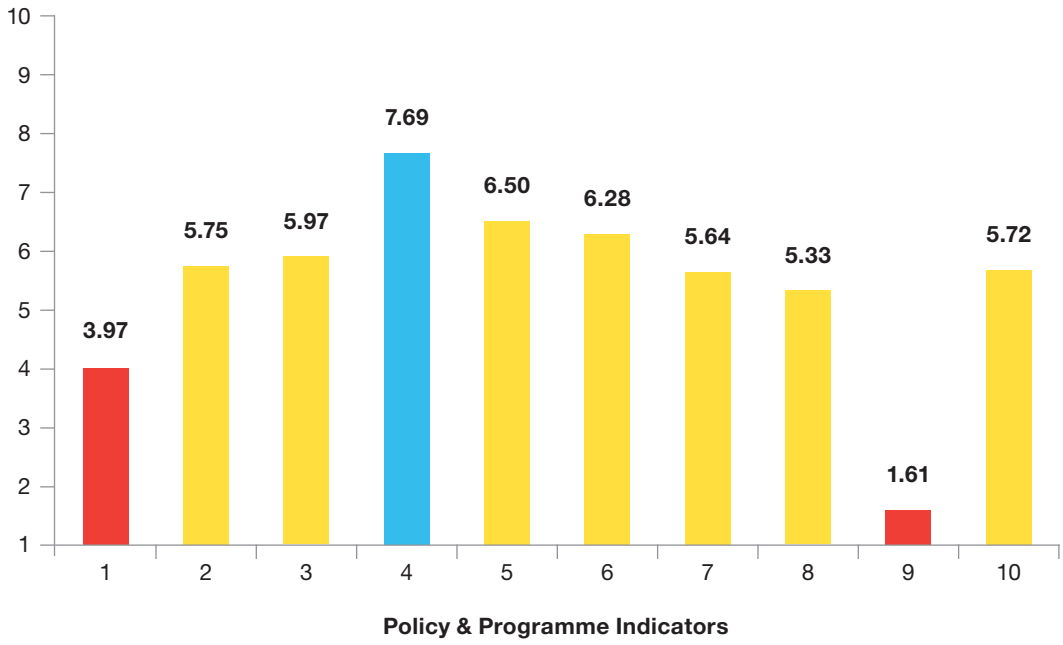


Figure 4:

Average scores for the 10 IYCF Policy and Programme Indicators.



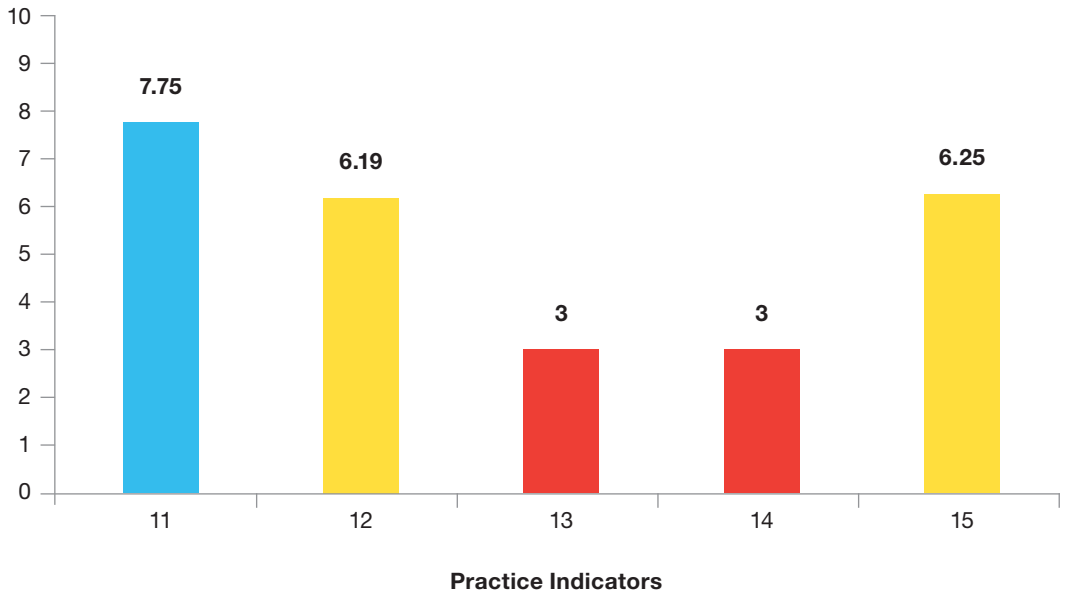


Figure 5:

Average scores for the 5 IYCF Practice Indicators.

and programmes, practices or overall score, indicating considerable gaps in *Global Strategy* implementation.

Average scores for each of the 10 Policy and programme indicators are presented in Figure 4; the overall average score for the 10 indicators is 5.4. By far the most poorly implemented recommendation of the *Global Strategy* in the European region is preparedness and planning for appropriate and safe IYCF in emergencies, reaching an average score of only 1.6 out of 10. The other Indicator in the red zone is 'National Policy, Programme and Coordination', suggesting a lack of commitment of European governments towards establishing national breastfeeding committees, programmes and coordinators, essential for operationalization of the *Global Strategy*. The only Indicator in the blue zone, with an average score of 7.7, is 'Maternity protection', with no indicators reaching the green zone.

Indicators 11-15 look at IYCF practices, i.e. timely initiation of breastfeeding, exclusive breastfeeding for the first six months, median duration of breastfeeding, bottle feeding and the introduction of complementary foods. Figure 5 shows the average scores in the European countries where data are available. Despite the *Global Strategy* recommendation that babies be breastfed for two years of age or beyond, the average duration of breastfeeding in the 13 European countries with available data was 8.7 months, making this the most poorly adhered to practice. Similarly, avoidance of bottle feeding is very low, indicating that bottle feeding is a prevalent practice in Europe, despite its inherent risks.

Individual indicator findings

INDICATOR 1:
National policy, programme and coordination

Turkey is the only country that has been assessed as fully implementing this indicator, with Ukraine and Croatia also receiving high scores. Eleven countries (61%) have an official IYCF policy of which all but the United Kingdom adhere to WHO infant feeding recommendations. Eight countries (44%) have a national plan of action, but only three state that it is adequately funded (Turkey, Croatia, Ukraine). All but eight countries (Armenia, Georgia, France, Italy, United Kingdom, Austria, Portugal and Spain) have a national breastfeeding committee, and members meet regularly in six countries (Turkey, Croatia, Ukraine, Malta, North Macedonia and Georgia). Five of 18 countries (Turkey, Croatia, Ukraine, Malta and Belgium) have a national breastfeeding coordinator. Interestingly, all countries scoring less than 4 out of 10 points for this indicator are in the European Union, except for Bosnia and Herzegovina; they include France, Italy, Lithuania, Germany, United Kingdom, Austria, Portugal and Spain.

INDICATOR 2:
Baby-friendly Hospital Initiative

Almost one third of assessed countries (Georgia, Armenia, Moldova, North Macedonia and Malta) do not have any recently designated 'Baby-friendly' facilities (in Armenia, 22 facilities were designated between 1999

and 2008, but after 2008 the BFHI was discontinued, including reassessments), and five countries have over 50% (Turkey, Croatia, Ukraine, United Kingdom and Bosnia and Herzegovina), of which Turkey and Croatia have implemented BFHI in over 89% of facilities. Coverage of Baby-friendly facilities in the 13 countries that have introduced BFHI ranges between 5% and 94%. Almost all countries conduct the standard UNICEF/WHO 20-hour training course for maternity staff – with the exception of Moldova (although the UK uses a competency-based approach rather than 20 hours of training) – but only eight countries (44%) have integrated HIV recommendations into their BFHI programme, representing the criterion with the lowest score. Assessment of BFHI implementation includes interviewing health personnel and mothers in all but two countries (North Macedonia and Malta), with seven of 18 European countries (Austria, Lithuania, Georgia, Armenia, Moldova, North Macedonia and Malta) having no reassessment process in place, endangering the sustainability of the initiative. All countries, except Bosnia and Herzegovina, Lithuania, North Macedonia and Malta, have a time-bound programme, and global BFHI criteria have been adhered to by most countries, with France, Lithuania, Macedonia and Malta being the exception.

INDICATOR 3:
Implementation of the International Code of Marketing of Breastmilk Substitutes

None of the 18 European countries has fully implemented the International Code and subsequent WHA resolutions. Malta and Armenia received the highest scores, whereas Germany and Ukraine received the lowest. Just under half of the countries have a monitoring system in place and all but three (Turkey, Moldova, Ukraine) report having measures which provide for fines to be imposed on violators. Only four countries (22%) have reported violations to concerned agencies, with Armenia and Turkey having actually fined companies for violations in the last three years. Conflicts of interest and promotion of breast milk substitutes through the health system are common throughout Europe, endangering the health and wellbeing of mothers and babies.

INDICATOR 4:
Maternity protection

Overall the situation is good in Europe, with none of the 18 countries assessed providing less than 14 weeks of paid maternity leave in the formal sector, but only seven countries (39%) provide at least 26 weeks leave, the time required for mothers to exclusively breastfeed according to WHO recommendations. Encouragingly, all countries – except for the United Kingdom – allow at least one breastfeeding break or a reduction of hours for working breastfeeding mothers. Of those, only France and Malta do not pay mothers during the break. In the private sector, all countries ensure a minimum of 14 weeks paid maternity leave and breastfeeding breaks, except for Malta, France, UK and Spain, that offer only 14 weeks paid maternity leave. Turkey is the only country that ensures a workplace space for breastfeeding/expressing and childcare, in the formal sector; seven countries (39%) ensure neither, making this the most poorly adhered to recommendation for this indicator. In the informal sector, all countries provide at least some protective measures for working mothers, the exceptions being Germany, North Macedonia and Georgia. The important role of fathers is being increasingly recognised; hence, all but two countries (Austria and North Macedonia), provide at least three days' paternity leave, in both public and private sectors. Pregnant and breastfeeding women are protected by legislation from potentially harmful working conditions in all countries except Georgia, and there is legislation prohibiting discrimination against breastfeeding women in all countries except Spain.

INDICATOR 5:
Health and Nutrition Care Systems

According to the 18 available country reports, thirteen countries (72%) provide inadequate pre-service training of health care providers in IYCF, whereas just over half provide adequate in-service training. It is concerning that only two countries (Turkey and Ukraine) adequately train health workers on their obligations under the International Code, explaining the high prevalence of International Code violations within the health system throughout Europe. Adherence to mother-and-baby-friendly guidelines ensures that every woman and her newborn are protected from unnecessary practices that are not evidence-based, and are not respectful of their culture, bodily integrity, and dignity. Two-thirds of assessed countries have not disseminated mother-friendly guidelines to all facilities and personnel providing maternity care. Ten countries (56%) do not have adequate policies which enable mothers and babies to stay together when one is hospitalised, especially when the mother is hospitalised.

INDICATOR 6:
Mother Support and Community Outreach

In half the European countries all pregnant women have access to community-based antenatal and postnatal IYCF support, whereas in six countries (Georgia, Malta, Moldova, Portugal, Turkey, Ukraine) there is adequate support available at birth, which is particularly important for timely initiation of breastfeeding. In only three countries – Croatia, Moldova, Ukraine – are community-based support services, such as Mother Support Groups, integrated into an overall IYCF policy. Training of community-based volunteers and health workers is the most poorly implemented criterion, with only Belgium providing adequate training on IYCF skills to community workers.

INDICATOR 7:
Information Support

Of the 18 assessed European countries, only seven (Turkey, Malta, Italy, Armenia, Ukraine, Croatia and Portugal) were found to have a national strategy that ensures all IYCF materials are free from commercial influence. Similarly, only seven countries (39%) reported including information in IYCF materials/ messages on the risks of artificial feeding; they are Turkey, Malta, Georgia, Armenia, North Macedonia, Moldova and Bosnia and Herzegovina. Information on the safe preparation of powdered infant formula, in line with WHO/FAO guidelines, is provided in six countries (Turkey, Malta, Italy, Georgia, North Macedonia and the United Kingdom), meaning that 12 European countries do not include this vital information in their IYCF materials. Individual counselling on IYCF is fully provided through the national health system in only half of the assessed countries, and group education and counselling services are widely available in only five (Turkey, Georgia, Ukraine, Croatia and Austria). IYCF activities, such as commemorating World Breastfeeding Week, are being implemented at a local level and are free from commercial interests in less than half of the countries assessed.

INDICATOR 8:
Infant feeding and HIV

Nine European countries (50%) reported including the topic of infant feeding and HIV in their national IYCF policy, of which only five (Portugal, Moldova, Ukraine, Georgia and Armenia) give effect to the International Code. Only a third of the countries provide training to health staff and community workers on HIV and infant feeding policies, the risks associated with various feeding options and how to provide counselling and support. Other countries do so only partially, as part of the BFHI. Voluntary and confidential HIV testing and counselling should be offered routinely to all couples who are considering pregnancy, as well as to pregnant women and their partners. Four countries, all in the European Union, report that this service is not available, with another three only partially. The majority of countries provide at least some degree of counselling and follow-up to HIV-positive mothers and support to ensure adherence to ARVs, the exceptions being Belgium and Germany. Despite WHO recommendations, only two countries – Portugal and Spain – undertake special efforts to counter misinformation on HIV and IYCF, and promote/ support six months of exclusive breastfeeding in the general population. Very few countries (Portugal, Moldova, Ukraine) have monitoring systems in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV-negative or of unknown status.

INDICATOR 9:
Infant Feeding During Emergencies

Only one country – North Macedonia – has a national policy on IYCF in emergencies (IYCF-E) that contains all the basic components of Operational Guidance on Infant Feeding in Emergencies. Similarly, only North Macedonia has appointed a person tasked with responsibility for national coordination with relevant partners. Every country is expected to have an emergency preparedness and response plan which includes interventions that create an enabling environment for breastfeeding, such as counselling by appropriately trained counsellors, support for re-lactation and wet-nursing, and protected spaces for breastfeeding; again, only North Macedonia fully complies with this recommendation. Measures to minimize the risks of artificial feeding, including a statement on avoidance of donations of breast milk substitutes, bottles and teats, have been undertaken by only two countries (11%). Lack of allocated resources weakens the ability of a government to act in emergency situations; Turkey was the only country

to report adequate resources for implementation of their emergency preparedness and response plan. Relevant health care personnel need to be trained for emergency management; not a single country reported IYCF-E being fully integrated into pre- and in-service training of relevant health care personnel and emergency management staff, making this the most poorly rated criterion.

INDICATOR 10:
Monitoring and Evaluation

Four countries (Turkey, Georgia, Portugal, Ukraine) have built monitoring and evaluation components into major IYCF programme activities, whereas five countries (28%) have integrated monitoring of IYCF practices into their national nutritional surveillance system and/or health information system. Data on progress made in implementing IYCF programme activities are routinely collected at the sub-national and national levels in five countries (Turkey, Georgia, Portugal, Armenia, Croatia). These data are reported to key decision-makers in seven countries (39%) but are used by programme managers to guide planning and investment decisions in only five (Turkey, Portugal, Ukraine, Armenia, Croatia).

INDICATOR 11:
Early Initiation of Breastfeeding

WBT*i* indicator 11 estimates, based on nationally available data, the proportion of children born in the last 24 months who were put to the breast within one hour of birth. Data were available for 12 countries, given that a third of the assessed countries do not record the time of initiation of breastfeeding. Wide regional variability exists in reported initiation rates, from 21% in North Macedonia to 84% in Portugal, with an average rate of 57%.

INDICATOR 12:
Exclusive Breastfeeding for the First Six Months

WBT*i* indicator 12 assesses the proportion of babies 0-5·9 months of age who are exclusively breastfed, based on 24-hour recall. Rates vary widely across countries, with the lowest rate in France (10%) and the highest in Croatia (65%). Interestingly, Croatia has one of the highest proportions of 'Baby-friendly' maternity facilities in the European Region and offers 12 months of paid maternity leave. Overall, the rate of exclusive breastfeeding for infants under six months of age in the 16 countries which provided data for this indicator is 40%.

INDICATOR 13:
Median Duration of Breastfeeding

Median breastfeeding duration varied drastically, between three (United Kingdom) and 17 months (Turkey), with higher rates in less developed and non-EU countries. The average median duration of breastfeeding in the assessed countries was 8·7 months, far below the recommended 24 months. In only three countries – Georgia, Moldova and North Macedonia – does it reach the age of one, with only Turkey exceeding 12 months. Interestingly, in Turkey, the median duration of breastfeeding among girls and boys differs, with boys being breastfed approximately two months longer than girls.

INDICATOR 14:
Bottle feeding

WBT*i* indicator 14 estimates the proportion of babies 1-12 months of age who are fed with any foods or drinks (including breastmilk) from a bottle. Data were available for only nine countries, of which five used indirect data. The average rate of bottle feeding for the remaining four countries (Armenia, Moldova, Portugal, Turkey) is 58%, indicating that bottle feeding is a prevalent practice in Europe.

INDICATOR 15:
Complementary feeding

WBT*i* indicator 15 endeavours to determine the proportion of breastfed babies receiving complementary foods between six and nine months of age. Wide inter-country variability was noted, with North Macedonia rating this indicator at 28%, and Portugal, at the other end, recording 100%. Large variation was also noted within countries, with some mothers commencing complementary foods as early as seven days and others as late as 305 days (France). The median age of introduction of solid foods was found to be related to breastfeeding duration, with children who were never breastfed starting solids earlier (136 days) than children breastfed at least four months (166.5 days).

CONCLUSION

This report highlights the need for governments and policy-makers to develop or update comprehensive, cross-sectoral, multi-level IYCF policies and plans and ensure an adequate budget for their implementation. Governments need to appoint a national committee and coordinator to oversee the implementation of the plan if the Global Strategy is to be successfully implemented and children's rights to the best possible start in life are to be respected. As stated in the Global Strategy, ″Success ...rests first and foremost on achieving political commitment at the highest level and assembling the indispensable human and financial resources″.

Background

By Maryse Arendt and Irena Zakarija-Grković

> **If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics.[8]**
>
> *– Keith Hanson, Vice President for Human Development, World Bank Group*

Breastfeeding gives ALL children the best start in life. No matter where an infant is born, into which family, suburb, country, continent, all newborns have access to the perfect form of sustenance for human babies – mother's milk. This perfect food for human beings, that has been fine-tuned over millions of years, provides all children with equal opportunities to thrive, both physically, mentally and socially. Hence it is up to the global community to make this happen.

Breast milk not only ensures optimal nutrition but strengthens babies' defence mechanisms, and stimulates cognitive development, leading to lower health care costs, healthier families, and a smarter workforce.[9] Breastfeeding reduces morbidity and mortality from diarrhoea and respiratory infections, the main causes of death worldwide. About half of all diarrhoea episodes and a third of respiratory infections could be avoided by breastfeeding.[10] Researchers have calculated that universal optimal breastfeeding could save the lives of more than 800,000 children per year.[11] Children and adolescents who were breastfed as babies are less likely to be overweight or obese or have type-2 diabetes in adulthood.[12] **Exclusive breastfeeding from birth to 6 months of age and continued breastfeeding up to 2 years and beyond are thus recommended for optimal growth and development.[13]**

When mothers breastfeed, women's health is also protected and everyone benefits. It has been found that breastfeeding decreases the risk of mothers developing breast cancer, ovarian cancer, type 2 diabetes, and heart disease.[14] It is estimated that increased breastfeeding could avert 20,000 maternal deaths each year due to breast cancer.[15] The 2016 'European Code Against Cancer' states: 'Breastfeeding reduces the mother's cancer risk. If you can, breastfeed your baby.'[16] The benefits are universal: they are as relevant to mothers and children living in high-income countries as to those living in middle- and low-income countries.

Conversely, low rates and early cessation of breastfeeding have important adverse health and social implications for women, children, the community and the environment; they result in greater expenditure on national health care provision and increased inequalities in health. About US$302 billion per year in economic losses

8 Hansen K. Breastfeeding: a smart investment in people and in economies. Lancet 2016;387:416

9 UNICEF and WHO (2017) A global breastfeeding call to action https://www.unicef.org/nutrition/index_98477.html

10 Victora CG et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet 2016; 387:475-90

11 Black RE et al. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet 2013;382(9890):452-477.

12 Horta BL, Loret de Mola C, Victora CG. Long-term consequences of breastfeeding on cholesterol, obesity, systolic blood pressure and type 2 diabetes: a systematic review and meta-analysis. Acta Paediatr 2015;104:30-7

13 WHO recommendations on postnatal care of the mother and newborn. Geneva: World Health Organization, 2013 http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf?ua=1

14 Global Breastfeeding Collective. Breastfeeding and Gender Equality. New York, Geneva: UNICEF, WHO, 2018

15 Breastfeeding: achieving the new normal. Lancet 2016 Jan 30;387(10017)

16 European Code Against Cancer http://cancer-code-europe.iarc.fr/index.php/en/

have been associated with not breastfeeding, representing 0.49 percent of combined, worldwide gross national income.[17] The ecological consequences of not breastfeeding also need to be considered, as industrially manufactured breast milk substitutes result in emission of greenhouse gases, use of energy for the production, transport, sales and preparation of breast milk substitutes and generate a sizeable volume of non-degradable waste.[18]

Despite this, breastfeeding rates continue to fall short of global recommendations. The European Region has the lowest prevalence of exclusive breastfeeding in infants less than 6 months of all six WHO regions, with a median value of only 23%.[19] Even though the rate of early initiation of breastfeeding is high in some countries, exclusive breastfeeding rates drop rapidly after three months and are very low at 6 months. The reasons are diverse but include: the promotion of breast-milk substitutes, high participation of women in the labour market without sufficient paid maternity leave, lifestyle choices, lack of awareness of the risks of not breastfeeding and insufficient knowledge among health professionals on how to support breastfeeding women.

In addition to being a public health priority, the act of being breastfed is a basic human right. The Convention on the Rights of the Child,[20] adopted by the UN General Assembly in 1989 and ratified by all European countries, states in article 24 that ˝Parties recognize the right of the child to the enjoyment of the highest attainable standard of health... ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents". In 2019, the 30th anniversary of the adoption of the Convention on the Rights of the Child was celebrated, providing all countries with a new opportunity to strengthen their commitment to this pledge.

In the last 10 years, the importance of breastfeeding and implementation of the *International Code of Marketing of Breastmilk Substitutes* have been mentioned in several important human rights' texts and technical documents, including: a *Technical Guidance* from the Office of the High Commissioner on Human Rights,[21] a *Joint Statement* from United Nations human rights' experts,[22] four *General Comments* from treaty bodies (two from the Convention on the Rights of the Child, one from the Commission on Eliminating Discrimination against Women and one from the Committee on Economic, Social and Cultural Rights),[23] three reports from the Special Rapporteur on the Right to Food and one report from the Special Rapporteur on the Right to Health.[24] In particular, the 2016 joint statement from United Nations human rights' experts emphasizes that "Breastfeeding is a human rights issue for both the child and the mother".

There is considerable scope for increasing the rates of exclusive and continued breastfeeding, in line with WHO recommendations.[25] In the 2018 WHO/EURO progress report on monitoring policy implementation, the authors conclude "Other areas might have to be "reinvigorated" or extended, such as support for breastfeeding and

---

17 Rollins NC et al. Why invest, and what it will take to improve breastfeeding practices? Lancet 2016;387:491-504

18 Dadhich JP et al. Report on Carbon Footprints Due to Milk Formula. BPNI. https://www.bpni.org/report/Carbon-Footprints-Due-to-Milk-Formula.pdf

19 Bosi AT, Eriksen KG, Sobko T, Wijnhoven TM, Breda J. Breastfeeding practices and policies in WHO European Region Member States. Public Health Nutr 2016;19:753-64

20 United Nations General Assembly. Convention on the Rights of the Child. New York, 1989 http://www.unicef.org/crc/crc.htm

21 Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (2014) https://www.ohchr.org/EN/Issues/Children/TechnicalGuidance/Pages/TechnicalGuidanceIndex.aspx

22 Joint Statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breastfeeding (2016) https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871

23 CRC Committee's General Comments No 15 on the right to health (2013) and No 16 children's rights and the business sector (2013) https://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=5&DocTypeID=11; CEDAW Committee's General Recommendation No 34 on rural women (2016) https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GC/34&Lang=en; CESCR Committee's General Comment No 24 on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities (2017) https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E/C.12/GC/24&Lang=en

24 Interim and final reports of 2014 and interim report of 2016 by the UN Special Rapporteur on the Right to Food; Annual report of 2015 by the UN Special Rapporteur on the Right to Health

25 WHO Europe. Better food and nutrition in Europe: a progress report monitoring policy implementation in the WHO European Region (2018) http://www.euro.who.int/__data/assets/pdf_file/0005/355973/ENP_eng.pdf?ua=1

appropriate complementary feeding if Member States are to achieve the ambitious goals they have set for themselves." Some support was provided a decade ago when the European Commission funded the development of a Blueprint for Action.[26] Unfortunately, only a handful of countries and local health authorities within countries used the Blueprint for Action to develop and implement concrete plans.[27]

The WHO 2017 'Report of the Commission on Ending Childhood Obesity' recommends several actions related to breastfeeding for member states, including: ensuring that legislation and regulations on the marketing of breast milk substitutes adhere to all the provisions in the International Code of Marketing of Breast milk Substitutes and subsequent related Health Assembly resolutions, establish regulations for all maternity facilities to practice the 'Ten Steps to Successful Breastfeeding', build or enhance assessment systems to regularly verify maternity facilities' adherence and enact legislation for the provision of maternal labour rights.[28]

In a further attempt to decrease the obesity epidemic in Europe, The *European Food and Nutrition Action Plan 2015-2020* (2014) calls upon all member states ˝to protect, promote, support breastfeeding and address barriers to adequate breastfeeding˝.[29] Similarly, the *EU Action Plan on Childhood Obesity 2014-2020* recommends member states promote early childhood services and maternity care practices that empower new mothers to breastfeed and promote breastfeeding through national health strategies.[30]

The most recent World Health Assembly (WHA) resolution (2018), adopted by all present European member states, contains further recommendations for actions to protect, promote and support breastfeeding. The resolution recalls the commitment by member states to implement relevant international targets and action plans, including *WHO's Global Maternal, Infant and Young Child Nutrition Targets* for 2025[31], *WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases* 2013-2020[32] and the *Rome Declaration on Nutrition*[33] resulting from the Second International Conference on Nutrition held in 2014. It also urges member states to: (1) increase investment in development, implementation, monitoring and evaluation of laws, policies and programmes aimed at protection, promotion, including education, and support of breastfeeding; (2) reinvigorate the Baby-friendly Hospital Initiative; (3) implement and/or strengthen national mechanisms for effective implementation of the International Code of Marketing of Breast milk Substitutes, as well as other WHO evidence-based recommendations; (4) promote timely and adequate complementary feeding; (5) continue taking all necessary measures in the interest of public health to implement recommendations to end inappropriate promotion of foods for infants and young children; (6) take all necessary measures to ensure evidence-based and appropriate infant and young child feeding during emergencies, including through preparedness plans, capacity-building of personnel working in emergency situations, and coordination of intersectoral operations.

The recently founded Global Breastfeeding Collective,[34] led by UNICEF and WHO, brings together implementers and donors from governments, philanthropies, international organizations and civil societies with the aim of creating a world in which all mothers have the technical, financial, emotional, and public support they need to start breastfeeding within an hour of a child's birth, to breastfeed exclusively for six months,

---

26 EU Project on Promotion of Breastfeeding in Europe. Protection, promotion and support of breastfeeding in Europe: a blueprint for action (revised). European Commission, Directorate Public Health and Risk Assessment, Luxembourg, 2008

27 Cattaneo A, Burmaz T, Arendt M et al. Protection, promotion and support of breast-feeding in Europe: progress from 2002 to 2007. Public Health Nutrition 2010;13:751-9

28 Report of the Commission on Ending Childhood Obesity: implementation plan http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf

29 European food and nutrition action plan 2015-2020 http://www.euro.who.int/__data/assets/pdf_file/0008/253727/64wd14e_FoodNutAP_140426.pdf

30 EU Action Plan on Childhood Obesity 2014-2020 https://ec.europa.eu/health//sites/health/files/nutrition_physical_activity/docs/childhoodobesity_actionplan_2014_2020_en.pdf

31 WHO's Global Maternal, Infant and Young Child Nutrition Targets for 2025 https://www.who.int/nutrition/global-target-2025/en/

32 WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 https://www.who.int/nmh/events/ncd_action_plan/en/

33 Rome Declaration on Nutrition and its Framework for Action http://www.fao.org/3/a-ml542e.pdf ; http://www.fao.org/fsnforum/sites/default/files/files/107_ICN2-FFA/ML079_ICN2_FfA_en.pdf

34 Global Breastfeeding Collective https://www.unicef.org/nutrition/index_98470.html

and to continue breastfeeding - with complementary foods - for two years or beyond. The Collective's mission is to rally political, legal, financial and public support, so breastfeeding rates increase, benefitting mothers, children, and society. Step seven of their *Call to Action* is to ″strengthen monitoring systems that track the progress of policies, programmes, and funding towards achieving both national and global breastfeeding targets.″[35] The WBT*i* is the perfect tool to address this challenge.

The aim of this report is to:

1) Draw the attention of national and European politicians/policy-makers to the importance of optimal IYCF;
2) Raise awareness among national and European politicians/policy-makers of sub-standard IYCF policies, programmes and practices in Europe, based on the WBT*i* tool;
3) Highlight gaps in IYCF policies, programmes and practices, based on the WBT*i* tool, so that national and European politicians/policy-makers know where to invest resources;
4) Provide recommendations, based on best practices in Europe, on how IYCF policies and programmes can be strengthened in order to improve practices;
5) Motivate all countries in the European region to take part in WBT*i* and repeat the evaluation every 3 - 5 years.

Success in breastfeeding in not the sole responsibility of a woman – the promotion of breastfeeding is a collective societal responsibility.[36]

35 Call to Action https://www.who.int/nutrition/topics/global-breastfeeding-collective/en

36 Rollins NC, Bhandari N, Hajeebhoy N et al. Why invest, and what it will take to improve breastfeeding practices? Lancet 2016;387:491-504

The WBT*i* tool and process of assessment

The WBT*i* Tool

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative project developed by the Breastfeeding Promotion Network of India (BPNI)/IBFAN Asia to assess the status and benchmark the progress of the implementation of the *Global Strategy for Infant and Young Child Feeding* at national level. The tool used for this purpose is based on two global schemes: the first is WABA's GLOPAR (Global Participatory Action Research) and the second, WHO's Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes. The WBT*i* has 15 indicators: ten linked to policies and programmes and five to infant feeding practices (Table 1). Each indicator used for individual country assessment has the following components: **Background** on why the practice, policy or programme component is important, **Key question** that needs to be investigated, a list of **Key criteria** to be used for assessment, possible **Sources of Information**, **Gaps** identified, agreed upon **Recommendations** and **Conclusions**. The findings are scored and colour-rated to clearly indicate where the country stands. Each indicator is scored on a scale of 10; thus, the maximum score for 'policy and programmes' is 100,

Table 1: **WBT*i* indicators.**

Part I: policy and programmes (Indicator 1-10)	Part II: infant feeding practices (Indicator 11-15)
1. National Policy, Programme and Coordination	11. Early Initiation of Breastfeeding
2. Baby-friendly Hospital Initiative	12. Exclusive Breastfeeding
3. Implementation of the International Code of Marketing of Breastmilk Substitutes	13. Median Duration of Breastfeeding
4. Maternity Protection	14. Bottle Feeding
5. Health and Nutrition Care Systems	15. Complementary Feeding
6. Mother Support and Community Outreach	
7. Information Support	
8. Infant Feeding and HIV	
9. Infant Feeding During Emergencies	
10. Monitoring and Evaluation	

Scores	Colour-coding
0 – 3.5	RED
4 – 6.5	YELLOW
7 – 9	BLUE
> 9	GREEN

Table 2: **Colour coding for WBT*i* policy and programme indicators**
(maximum score: 10)

and 50 for 'infant feeding practices', giving a total score of 150 on *Global Strategy* implementation (Table 2).

The WBT*i* Process

The process of conducting a WBT*i* assessment consists of each country selecting a 'national WBT*i* coordinator' who forms a core group of approximately 4-5 people, representing government, professional and relevant non-governmental organisations, without conflicts of interest. The WBT*i* Guide Book provides an overview of the WBT*i* process, and is a good starting point for national team members.[37] Thorough assessment of individual indicators is conducted by core group members using the WBT*i* Assessment Tool.[38] Assessment is based on available national data (policies, documents, official websites, survey findings, professional guidelines...) and/or on interviews with key government officials, as outlined in the WBT*i* 'Possible Sources of Information' document.[39] Once scoring of indicators, identified gaps and recommendations are agreed upon, a preliminary report, based on the WBT*i* Report Template,[40] is forwarded to a wider audience of partners for comments and consensus. A final report, with incorporated suggestions, is sent to the Global WBT*i* Secretariat for review and validation. This is then fed into the WBT*i* Web-Based Toolkit©, which objectively quantifies the data to provide a colour-coded rating in Red, Yellow, Blue or Green, in ascending order of performance (Table 2). Once finalised, the Report, and accompanying summary Report Card, is published on the WBT*i* website,[41] and findings are shared with the wider audience, including government officials and professional organisations, via a 'Call to Action'. Re-assessment is conducted every 3-5 years to track trends on the

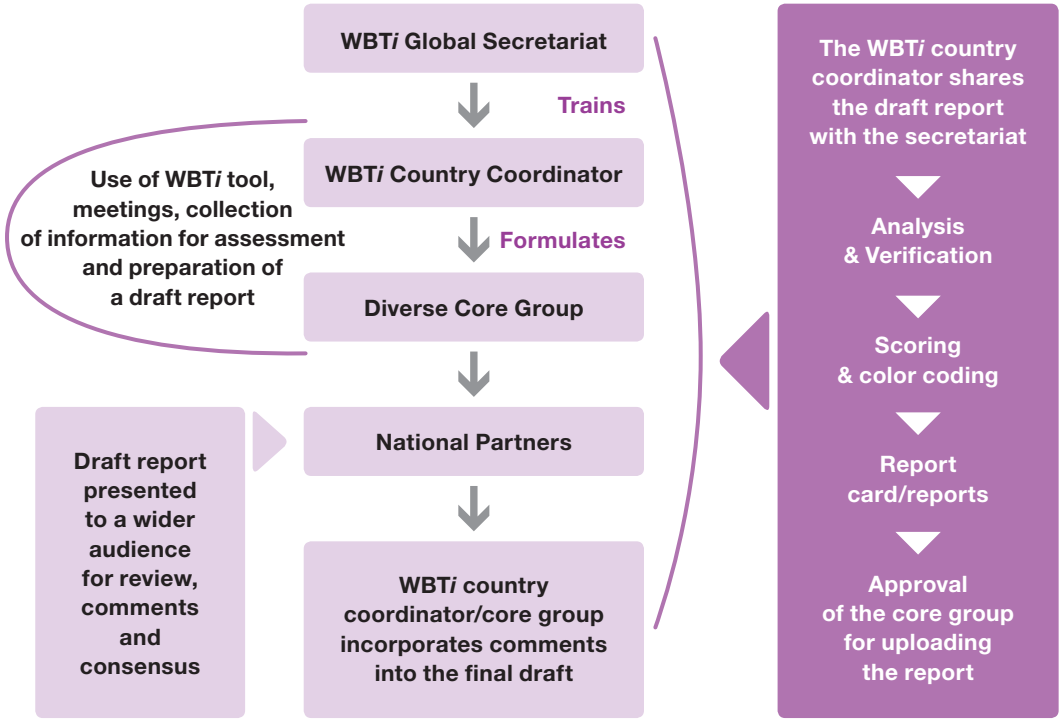


Figure 1:
WBT*i* Assessment Process
(Source: The WBT*i* Guide Book (2018))

37 http://worldbreastfeedingtrends.org/guide-book-wbti/

38 http://worldbreastfeedingtrends.org/wbti-tool/

39 http://worldbreastfeedingtrends.org/wp-content/uploads/2015/03/docs/WBTi-indicators-and-their-possible-source-of-information.pdf

40 http://worldbreastfeedingtrends.org/reporting-template/

41 http://worldbreastfeedingtrends.org/country-report-wbti/

various indicators, assess progress and study the impact of any particular intervention (Figure 1).

The European Report

In May 2018, the WBT*i* was presented at the European Lactation Consultants Alliance Conference, held in Rotterdam, The Netherlands. This provided the opportunity for interested and involved individuals to get together during the conference and share experiences on WBT*i* implementation, which led to the formation of an email group of European WBT*i* coordinators. Inspired by the document 'ARE OUR BABIES FALLING THROUGH THE GAPS?', and with the approval of the document's author, a core group of European coordinators decided to produce a similar report on the state of implementation of the *Global Strategy* in Europe. In June 2018, core group members were invited by the designated coordinator to choose Indicators for reporting and to adhere to the format used in the earlier document. Between June and October 2018, each core group member carefully read all 18 published WBT*i* European reports[42] for their chosen indicator/s and presented the findings under the following headings: **Background**, **Key Question**, **Criteria for Assessment**, **Findings** and **Detailed Findings**. Findings are depicted using colour-coded tables to aid interpretation. In addition, **Key Findings**, **Key Recommendations** and **Best Practices** are highlighted in the report. The 'Best Practice' scenarios, new to this report, represent real-world examples of what European countries have done to improve *Global Strategy* implementation. They endeavour to highlight how the highest-ranking countries for each indicator achieved their top scores, in the hope that they will serve as an example and inspiration to others. Between October 2018 and May 2019, several iterations of the Report were produced, involving contacting national WBT*i* teams for clarification of findings, standardising reporting format and achieving consensus on Report content.

42 http://worldbreastfeedingtrends.org/country-report-wbti/

European IYCF Policy and Programmes: Gaps and Achievements

1. National Policy, Programme & Coordination

Background

The *Global Strategy* calls upon governments to appoint a national breastfeeding coordinator and to establish a NBC, composed of multi-sectoral representatives from government departments, nongovernmental organizations, and relevant health personnel. Operational target 5 of the *Global Strategy* requires that governments develop, implement, monitor and evaluate a comprehensive policy on IYCF, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.

The WBT*i* indicator on National policy, programme and coordination addresses this particular need of having a national IYCF policy, which is well implemented, and a government plan to support the policy. Besides looking at whether there is a mechanism for coordination, the subset of questions addresses whether the policy has an attached plan and a budget for putting the plan into action, as well as the status of its implementation.

Key question

Is there a national infant and young child feeding/ breastfeeding policy that protects, promotes and supports optimal IYCF and is the policy supported by a government programme? Is there a mechanism to coordinate the policy, such as a NBC and a Coordinator for the Committee?

Criteria for assessment and scoring

Table 1.1 gives the criteria for assessment and scoring of the indicator. The eight criteria have scores ranging from 0.5 to 2 and the total score is calculated by adding the scores for the eight criteria. Table 1.2 provides the scores for each criterion and the total score out of a maximum of 10. The total score is colour-coded.

Findings

The average score in 18 European countries for this indicator is 4 (range: 0-10). Three countries, TR, HR and UA, reached the green zone, with only Turkey scoring a full 10 points. Malta is the only country with a score between 7 and 9 points, whereas five countries scored between 4 and 6.5 (MK, MD, AM, BE, GE). The majority of countries are in the red zone, all of which are in the European Union - except for Bosnia and Herzegovina - and scored less than 4 out of a total of 10 points. They include: BA, FR, IT, LT, DE, UK and AT, with PT and ES scoring zero each.

Detailed findings

A detailed analysis of the sub-scores for each of the eight criteria (Table 1.2) clearly indicates the gaps in European national policy, programme and coordination. Criterion 1.1 reveals that seven of the

Table 1.1:

Assessment criteria and scores for WBT*i* Indicator 1.

No.	Criteria	Score
1.1	A national IYCF/breastfeeding policy has been officially adopted/approved by the government	1
1.2	The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond	1
1.3	A national plan of action developed based on the policy	2
1.4	The plan is adequately funded	2
1.5	There is a National Breastfeeding Committee/IYCF Committee	1
1.6	The National Breastfeeding (IYCF) Committee meets, monitors and reviews on a regular basis	2
1.7	The National Breastfeeding (IYCF) Committee links effectively with all other sectors like health, nutrition, information etc.	0.5
1.8	The NBC is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level	0.5
Total possible score		**10**

Table 1.2:

The state of National Policy, Programme and Coordination in 18 European countries.

Country	Criteria								Total score
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	
Turkey (TR)	1	1	2	2	1	2	0.5	0.5	**10**
Croatia (HR)	1	1	2	2	1	2	0	0.5	**9.5**
Ukraine (UA)	1	1	2	2	1	2	0	0.5	**9.5**
Malta (MT)	1	1	2	0	1	2	0.5	0.5	**8**
North Macedonia (MK)	0	1	2	0	1	2	0	0	**6**
Moldova (MD)	1	1	2	0	1	0	0	0	**5**
Armenia (AM)	1	1	2	0	0	0	0	0	**4**
Belgium (BE)	0	0	0	0	1	2	0.5	0.5	**4**
Georgia (GE)	1	1	2	0	0	0	0	0	**4**
Bosnia and Herzegovina (BA)	1	1	0	0	1	0	0	0	**3**
France (FR)	1	1	0	0	0	0	0	0	**2**
Italy (IT)	1	1	0	0	0	0	0	0	**2**
Lithuania (LT)	0	1	0	0	1	0	0	0	**2**
Germany (DE)	0	0	0	0	1	0	0	0	**1**
United Kingdom (UK)	1	0	0	0	0	0	0	0	**1**
Austria (AT)	0	0	0	0	0	0	0.5	0	**0.5**
Portugal (PT)	0	0	0	0	0	0	0	0	**0**
Spain (ES)	0	0	0	0	0	0	0	0	**0**
Average score									**4**

18 European countries do not have an approved national policy on IYCF; these are MK, BE, LT, DE, AT, PT and ES. The scores for criterion 1.3 show that of those that have a policy, BE, BA, FR, IT, LT, DE, UK, AT, PT and ES do not have a national plan of action.

The criteria with the worst scores are 1.4, 1.6, 1.7 and 1.8. Only 3 out of 18 European countries (TR, HR and UA) have a budget for implementing IYCF policies and plans (criterion 1.4). Despite 10 countries reporting that they have a NBC, in only six countries does the NBC meet regularly (criterion 1.6); these are TR, HR, UA, MT, MK and BE, and in only four countries (TR, MT, BE and AT) is it considered to link effectively with other relevant sectors (criterion 1.7). TR, HR, UA, MT and BE are the only countries with NBCs headed by a National Coordinator with clear terms of reference (criterion 1.8).

Having a good policy is clearly not enough; countries have to develop operational plans with adequate funds. The implementation of these plans should be supervised by national committees and coordinators with clear terms of reference, as recommended several years ago by the *Global Strategy*. These committees and coordinators need to link effectively with other sectors with a bearing on IYCF.

Key findings

- Only 3 of 18 European countries have a budget allocated for implementing IYCF policies and plans.
- Less than a third of 18 European countries has a NBC, led by a Coordinator, that meets regularly and collaborates with other relevant sectors.

Key recommendations

- Develop or update a comprehensive, cross-sectoral, multi-level IYCF policy and plan. Ensure an adequate budget for its implementation.
- Appoint a national committee and a national coordinator, with clear terms of reference, to oversee the implementation of the plan.

Best practice

Since 1991 Turkey has been actively engaged in decision-making and activities aimed at improving IYCF policies and programmes. Turkey's top score derives from longstanding dedication to IYCF and from a combination of external support (UNICEF) and internal processes enabling implementation of agreed decisions.

2. Baby-friendly Hospital Initiative (BFHI)

Background

The BFHI was launched by WHO and UNICEF in 1991 as a global effort to implement policies and practices that protect, promote and support breastfeeding in maternity facilities. Since its launch, BFHI has grown, with more than 152 countries around the world participating in implementing the 'Ten Steps to Successful Breastfeeding', the foundation of the initiative. This has had measurable and proven impact on hospital practices, increasing the likelihood of babies being exclusively breastfed for the first six months.

In response to the *Global Strategy for Infant and Young Child Feeding*, the HIV pandemic and other new evidence, WHO and UNICEF updated the BFHI in 2006 and, more recently, in 2018. The updated materials integrate implementation of the International Code of Marketing of Breastmilk Substitutes, Mother-friendly care, care of pregnant women and mothers in the context of HIV and care of infants in neonatology units as well as expansion towards other types of health facilities in the community.

Key questions

- What percentage of hospitals/maternity facilities (both public and private) have been designated or re-assessed as "Baby-friendly" in the last 5 years based on global or national criteria?
- What is the quality of BFHI programme implementation?

Criteria for assessment and scoring

Evaluation encompasses a quantitative score indicating the percentage of designated hospitals, and eight qualitative criteria covering training, monitoring, assessment, reassessment, timeliness, HIV integration and compliance with global criteria (Table 2.1).

Findings

The average score for all 18 European countries was 5.8 out of 10. Five European countries – AM, GE, MD, MK and MT – currently have no Baby-friendly designated maternity facilities, constituting nearly one third of participating countries. Coverage of Baby-friendly facilities in the 13 countries with designated maternity hospitals ranges between 5% and 94%. Between 1999 and 2008 AM accredited 22 maternity hospitals and 10 polyclinics as Baby Friendly; however, in 2008 the BFHI was discontinued and no reassessments were carried out. The majority of European countries are coded yellow, indicating a score between 4 and 6.5 out of a total of 10. Five countries have over 50% Baby Friendly hospitals; these are TR, HR, UA, UK and BA, of which only TR and HR have implemented BFHI in over 89% of their maternity facilities, presenting a role model for other European countries.

Detailed Findings

The country scores on the different criteria are shown in Table 2.2. All 18 European countries, except for MD, use the UNICEF/WHO 20-hour course for training of maternity staff, and the UK uses a competency-based approach rather than 20 hours of training. The WBT*i* report for MD documents a lack of governmental support for BFHI training. Five out of 18 countries do not have a standard monitoring system for BFHI implementation in place; namely HR, LT, AM, MK and MT. Most countries have an assessment system in place, with only two countries, MK and MT, not interviewing health personnel or mothers in maternity facilities as part of their assessment process. Seven out of 18 European countries, namely AT, LT, GE, AM, MD, MK and MT, have no reassessment process in place, constituting a high rate of lack of follow-up, leading to lack of consistency and sustainability in upholding BFHI standards. All countries, except BA, LT, MK and MT, have a time-bound programme to increase

Table 2.1:

Assessment criteria and scores for WBT*i* Indicator 2.

Quantitative 2.1		Qualitative 2.2 - 2.9	
Criteria	**Scoring**	**Criteria**	**Scoring**
0	0	**2.2)** BFHI programme relies on training of health workers using at least 20-hour training programme	1.0
0.1 - 20%	1	**2.3)** A standard monitoring system is in place	0.5
20.1 - 49%	2	**2.4)** An assessment system includes interviews of health care personnel in maternity and postnatal facilities	0.5
49.1 - 69%	3	**2.5)** An assessment system relies on interviews of mothers	0.5
69.1-89 %	4	**2.6)** Reassessment systems have been incorporated in national plans with a time bound implementation	1.0
89.1 - 100%	5	**2.7)** There is/was a time-bound programme to increase the number of BFHI institutions in the country	0.5
		2.8) HIV is integrated into the BFHI programme	0.5
		2.9) National criteria are fully compliant with global BFHI criteria	0.5
Total (10)	**5**	**Total possible score**	**5**

Table 2.2:

The state of BFHI implementation in 18 European countries

Country	Criteria									Total score
	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	
Turkey (TR)	5	1	0.5	0.5	0.5	1	0.5	0.5	0.5	10
Croatia (HR)	5	1	0	0.5	0.5	1	0.5	0.5	0.5	9.5
Ukraine (UA)	4	1	0.5	0.5	0.5	1	0.5	0	0.5	8.5
Bosnia/Herzegovina (BA)	4	1	0.5	0.5	0.5	1	0	0.5	0.5	8.5
United Kingdom (UK)	3	1	0.5	0.5	0.5	1	0.5	0	0.5	7.5
Portugal (PT)	2	1	0.5	0.5	0.5	1	0.5	0.5	0.5	7
Belgium (BE)	2	1	0.5	0.5	0.5	1	0.5	0	0.5	6.5
Spain (ES)	2	1	0.5	0.5	0.5	1	0.5	0	0.5	6.5
Italy (IT)	1	1	0.5	0.5	0.5	1	0.5	0.5	0.5	6
Germany (DE)	1	1	0.5	0.5	0.5	1	0.5	0	0.5	5.5
Austria (AT)	2	1	0.5	0.5	0.5	0	0.5	0	0.5	5.5
France (FR)	1	1	0.5	0.5	0.5	1	0.5	0	0	5
Lithuania (LT)	3	1	0	0.5	0.5	0	0	0	0	5
Georgia (GE)	0	1	0.5	0.5	0.5	0	0.5	0.5	0.5	4
Armenia (AM)	0	1	0	0.5	0.5	0	0.5	0.5	0.5	3.5
Moldova (MD)	0	0	0.5	0.5	0.5	0	0.5	0.5	0.5	3
North Macedonia (MK)	0	1	0	0	0	0	0	0	0	1
Malta (MT)	0	1	0	0	0	0	0	0	0	1
Average score										5.8

the number of BFHI facilities in the country. Only eight countries (TR, HR, BA, PT, IT, GE, AM and MD) have integrated HIV standards into their BFHI programme, representing the criterion with the lowest score. Global BFHI criteria have been adhered to at a national level by 14 European countries, with FR, LT, MK and MT being the exceptions.

Key findings

- Nearly a third of the included European countries have no Baby-friendly designated maternity facilities.
- Coverage of Baby-friendly facilities in the 13 countries with designated maternity hospitals ranges between 5% and 94%.
- There is inadequate monitoring and reassessment of Baby-friendly facilities.
- HIV criteria implementation is lacking.

Key recommendations

- Revitalization of BFHI in Europe, aiming for 100% implementation, using updated criteria.
- Regular monitoring and reassessment.
- Include BFHI in National Healthcare Standards and Accreditation Criteria.

Best practice

In Turkey, 905 out of 973 (93%) maternity facilities (both public & private) have been designated or reassessed as 'Baby-friendly'. This can be attributed to Turkey's political commitment to IYCF since 1991. Special efforts have been made over the decades to implement and monitor BFHI, withdrawing the title when deemed appropriate. The programme is mainly run by the Turkish Public Health Institute, including regular reporting. While the appointed coordinator, the director of the Turkish Public Health Institute, Department of Child and Adolescent Health, sends out reminders for self-evaluation to all Baby-friendly facilities on a regular basis, the Turkish Public Health Institute receives reports on the status quo of facilities every 6 months. The 18-hour course is also accessible online for all healthcare staff. Hospitals include it in their strategic plans to increase the number of Baby-Friendly units. Special reminders are sent to rural areas on a yearly basis. Cooperation of relevant institutions is enhanced by regular exchange and communication, e.g. between the Associations of Public Hospitals and the Directorate General for Private Health Services. Moreover, Baby-friendly has been expanded to other settings, including: general practitioners' offices, workplaces of both public and private employers and the general community, through municipalities and other local authorities.

3. Implementation of the International Code of Marketing of Breastmilk Substitutes

Background

The *International Code of Marketing of Breastmilk Substitutes* (the Code) was adopted by the WHA in 1981,[43] the world's highest health policy-setting body. The Code has been regularly updated and clarified by subsequent WHA Resolutions. When reference is made to "the Code" this automatically includes the subsequent Resolutions.

THE AIM OF THE CODE IS:
To contribute to the provision of safe and adequate nutrition for infants,
- *by the protection and promotion of breastfeeding,*
- *and by ensuring the proper use of breastmilk substitutes, when these are necessary,*
  - » *on the basis of adequate information*
  - » *and through appropriate marketing and distribution*

The products covered by the Code include:
- all formula and other milks for babies and children up to the age of 3 years
- any food or drink marketed for babies under the age of 6 months
- bottles
- teats

The Code restricts *marketing and promotion*, not the *use* or general *sale* of these products. It sets out the regulations needed to protect families from misleading marketing and to protect infant nutrition. Crucially, the Code ensures that families have access to accurate information about breastfeeding and about the safe and appropriate use of breast milk substitutes. It also states how breast milk substitutes should be appropriately distributed in special circumstances, such as in emergencies or in cases of HIV. Importantly, the Code applies to governments, manufacturers and distributors of breast milk substitutes, health workers (both professional and volunteer) and the health system. The Code calls on them all to avoid conflicts of interest.

Numerous international documents have called for all governments to implement the provisions of the Code in their entirety, including the *Innocenti Declaration*,[44] and the *Global Strategy for Infant and Young Child Feeding*.[45] The UN Committee on the Rights of the Child regularly examines whether governments have implemented the Code when assessing progress in meeting their obligations under the *Convention on the Rights of the Child*.[46] Human rights experts at the UN have also called for the implementation of the Code to protect

Figure 3.1: The Code prohibits idealising text and images on labels, but these are commonplace. Examples include baby animals, shield images implying that the product will protect the infant, and pseudo-scientific images such as molecules and DNA.

UK Photo. Credit Baby Milk Action.

43 WHO International Code of Marketing of Breastmilk Substitutes and subsequent Resolutions. Available at http://www.who.int/nutrition/netcode/resolutions/en/

44 Innocenti Declaration. Available at http://innocenti15.net/inno.htm

45 WHO (2003) Global Strategy for Infant and Young Child Feeding. Available at http://www.who.int/nutrition/topics/global_strategy/en/

46 Convention on the Rights of the Child. Available at https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

children and families.[47] It is the responsibility of governments to implement the Code into legislation and regulation, and to monitor and enforce these. Within the European Union, European Commission Directives are implemented in each Member State's own legislation. At the time of writing (October 2018), eleven of the 18 European countries which have completed the WBT*i* assessment process are members of the European Union. Currently the principal relevant European Union legislation only partially implements the Code and subsequent Resolutions. However, the Precautionary Principle is embedded in EU baby food and formula regulations.[48] This prevents formulas made with risky technologies, such as hormone-laced milk and genetically modified ingredients, and also those with high levels of sugar, from reaching the EU market.[49]

Key Questions

Have the *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA Resolutions been implemented? Has any new action been taken to give effect to the provisions of the Code?

Criteria for assessment and scoring

Table 3.1 gives the criteria for assessment and scoring of the indicator. Section 3a (questions 3.1 to 3.9) assesses the degree to which the Code is implemented in national law, up to a maximum score of 6; only the highest of these scores is counted. Section 3b (questions 3.10 to 3.13) assesses how effectively the country is enforcing those provisions (for a maximum score of 4). The scores for 3a and 3b are then combined for the total score out of 10 for Indicator 3.

Findings

None of the 18 countries covered in this report has fully implemented the International Code and at least some of the relevant WHA resolutions into their national legislation (Table 3.2). Overall, the most common situation is national legislation that includes only some of the articles of the Code. Only a third of these countries include the relevant WHA resolutions. Almost all of them do have some legislation on monitoring and/or enforcement, but only Armenia and Turkey report having actually fined any companies for violations in the last three years.

Detailed findings

Malta and Armenia stand out with a score of 9/10 and 8.5/10, respectively, on this indicator. Georgia is close behind at 7.5/10. Germany and Ukraine received the lowest scores in the European group, 4/10. This reflects the fact that only a few provisions implementing the Code are legislated in national law, such as through the regulations on dietetic goods (Germany) or through the BFHI and advertising law (Ukraine). Monitoring and enforcement are likewise weak in both countries (1/3).

47 United Nations Office of the High Commissioner on Human Rights. (2016) Joint statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breast-feeding. Available at https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871

48 Baby Milk Action. *The Precautionary Principle.* Available at http://www.babymilkaction.org/archives/16713

49 European Commission Directive 2006/141/EC (on infant formulae and follow on formulae, to be repealed 22 February, 2020). European Commission Directive 1999/21/EC (Food for special medical purposes). EU Regulation 609/2013 on Food Intended for Infants and Young Children, Food for Special Medical Purposes, and Total Diet Replacement for Weight Control (came into force across the EU on 20 July 2016). Specific EU delegated acts for each of these product categories come into effect in 2020/2021

Table 3.1:

Assessment criteria and scores for WBT*i* Indicator 3.

No.	Criteria	Score
3a:	**Status of the International Code**	
3.1	No action taken	0
3.2	The best approach is being considered	0.5
3.3	National measures awaiting approval (for not more than three years)	1
3.4	Few Code provisions as voluntary measure	1.5
3.5	All Code provisions as a voluntary measure	2
3.6	Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions	3
3.7	Some of the articles of the Code as law	4
3.8	All articles of the Code as law	5
3.9	Relevant provisions of World Health Assembly (WHA) Resolutions subsequent to the Code are included in the national legislation **a.** Provisions based on a least 2 of the WHA resolutions listed below are included* **b.** Provisions based on all 4 of the WHA resolutions listed below are included*	 5.5 6
3b:	**Implementation of the Code/National legislation**	
3.10	The measure/law provides for a monitoring system	1
3.11	The measure provides for penalties and fines to be imposed on violators	1
3.12	The compliance with the measure is monitored and violations are reported to concerned agencies	1
3.13	Violators of the law have been sanctioned during the last three years	1
Total possible score (3a+3b)		**10**

*3.9 The following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.

1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labelling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32)
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

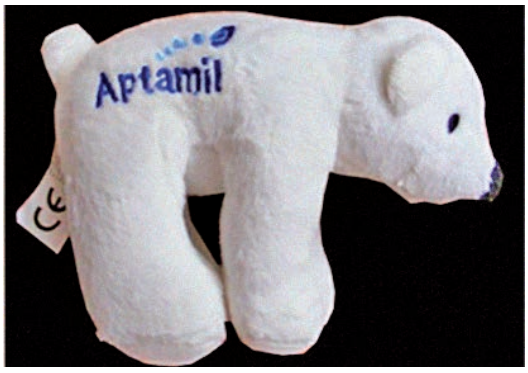


Figure 3.2: Gifts to parents and parenting clubs. Danone gives a branded bear as a gift to pregnant women and new mothers to encourage them to join its parenting club. Emails are sent to members of clubs, timed to key dates during pregnancy and the child's development after being born, for example, promoting a formula starter kit to pregnant women close to their due date.

UK Photo. Credit Baby Milk Action.

Figure 3.3: Gifts targeting health workers, using Nestlé's slogan "You're doing great", also used in Nestlé's online and television advertising for the brand.

UK Photo. Credit Baby Milk Action.

Table 3.2:

The state of the International Code in 18 European Countries.

Country	Score 3a	Criteria 3b				Score 3b	Total score
		3.10	3.11	3.12	3.13		
Malta (MT)	6	1	1	1		3	9
Armenia (AM)	5.5		1	1	1	3	8.5
Georgia (GE)	5.5		1	1		2	7.5
Lithuania (LT)	5.5		1			1	6.5
Belgium (BE)	5.5		1			1	6.5
Bosnia & Herzegovina (BA)	5.5		1			1	6.5
United Kingdom (UK)	4	1	1			2	6
Croatia (HR)	4	1	1			2	6
Portugal (PT)	4	1	1			2	6
Italy (IT)	4	1	1			2	6
North Macedonia (MK)	4	1	1			2	6
Austria (AT)	4		1	1		1	5
France (FR)	4		1			1	5
Spain (ES)	4		1			1	5
Turkey (TR)	4				1	1	5
Moldova (MD)	4	1				1	5
Ukraine (UA)	3	1				1	4
Germany (DE)	3		1			1	4
Average score	**4.5**					**1.6**	**6.0**

Figure 3.4: The screenshots above are from television and internet advertising for a follow-on milk and suggest that babies fed on the formula develop the balance, strength and stamina of a ballerina and the mental skills of a mathematical genius.

UK Photo Credit Baby Milk Action.

Key findings

- The provisions of the Code and relevant WHA resolutions are only partially implemented in national legislation. For instance, legislation only covers infant formula or first stage (0-6 months) formula, so companies easily circumvent regulations by developing products for other ages and by using cross-promotion of other products (Figure 3.2).
- Marketing of bottles and teats is not covered by European regulations.
- Conflicts of interest and promotion of breast milk substitutes through the health system and health workers is common throughout Europe. The baby feeding industry provides sponsorship and funding for health professional organisations, for continuing education, and sometimes even for government programmes. Displays, free samples, and gifts have been documented throughout Europe (Figures 3.3 and 3.4).
- Monitoring and enforcement mechanisms are weak or absent. Only two countries (AM and TR) reported sanctions against violators of the law in the last three years.

Key recommendations

- All governments should fully implement the Code and relevant WHA resolutions in legislation, including the 2016 WHO *Guidance on ending the inappropriate promotion of foods for infants and young children*[50]. This would ensure that:
  - » All milk drinks marketed at infants and children up to 3 years of age are covered.
  - » Labelling of baby food would be more closely regulated.
  - » Cross promotion of products would not be permitted.
- Marketing regulations should also cover bottles and teats.
- Promotion though the health system and through health workers should not be permitted. Government programmes, health professional organisations and education should be free of commercial sponsorship.
- Monitoring and enforcement mechanisms should be strong, and regular public reports made on penalties for infractions.

Best practice

Malta's high score (9/10) reflects strong political will; although Malta has not incorporated every article of the Code into legislation (some are voluntary), all four of the relevant WHA resolutions are included. Malta's Minister for Health and senior policy-makers agreed that this legislation was a priority. Moreover, Malta is one of only two countries (along with Armenia) to score 3/4 on monitoring and enforcement. Armenia's "Breastfeeding Promotion and Regulation of Marketing of Baby Food" law includes all the provisions of the International Code and the WHA resolutions listed in the WBT*i* Assessment Tool. Although the EU Directives do not cover all articles of the Code and relevant WHA resolutions, nor do they require strong enforcement of those laws, they do provide a required minimum standard across the European Union.

ACKNOWLEDGEMENTS: With thanks to Mike Brady and Baby Milk Action

50 http://www.who.int/nutrition/topics/guidance-inappropriate-food-promotion-iyc/en/

4. Maternity Protection

Background

In order to practice optimal IYCF, especially breastfeeding, maternity protection is vital. Exclusive breastfeeding requires mothers to be in close proximity to their babies, so that they can breastfeed responsively; therefore, mothers should be ensured a minimal of six months paid maternity leave in accordance with WHO's recommended duration of exclusive breastfeeding. Adequate maternity protection enables mothers to combine their productive role effectively with optimal feeding practices for their babies. There is increasing evidence that women tend to breastfeed longer with longer maternity leave. Recognizing the contribution of women, the ILO developed maternity protection through various conventions. Several countries have also enacted maternity protection legislation. The ILO Convention C183 and recommendation R191 cover seven key elements of maternity protection: scope, leave, benefits, health protection, job protection and non-discrimination, breastfeeding breaks and breastfeeding facilities. While these elements are broad enough to cover women in all sectors of the economy, in several countries they have been considered narrowly, thus only providing such protection to women working in the organized sector.

Key question

Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the ILO standards for protecting and supporting breastfeeding mothers, including those working in the informal sector?

Criteria for assessment and scoring

Table 4.1 shows the 10 criteria for assessing WBT*i* Indicator 4, with scores ranging from 0.5 to 2.

Findings

Table 4.2 shows the scores for the Indicator 4 criteria, with a maximum total of 10, with colour coding. The average score is 7.7 (range: 5-9.5). Only one country, LT, is in the green zone. Thirteen countries are in the blue zone: BA, HR, UA, TR, AM, BE, DE, IT, MD, AT, PT, MT and FR. The overall situation is good, as there is no country in the red zone. Four countries are coded yellow: UK, MK, ES and GE.

Detailed findings

According to criterion 4.1, none of the 18 countries assessed provide less than 14 weeks of paid maternity leave. Five countries provide maternity leave between 14 and 17 weeks: TR, BE, AT, FR and E, whereas six countries - UA, AM, IT, PT, MT and GE - provide maternity leave of 18-25 weeks. Only seven countries provide at least 26 weeks (LT, BA, HR, DE, MD, UK and MK), enabling mothers to breastfeed exclusively for six months, if they wish.

According to criterion 4.2, women covered by the national legislation are allowed at least one paid breastfeeding break or reduction of work hours daily in all countries except MT, FR and UK. According to criterion 4.3, legislation obliges private sector employers of women in the country to give at least 14 weeks of paid maternity leave in LT, BA, HR, UA, TR, AM, BE, GE, IT, MD, AT, PT, MK and DE, and paid nursing breaks in MD, FR, UK and ES.

According to criterion 4.4, there are provisions in national legislation for work site accommodation for breastfeeding (like a room for breastfeeding/ breastmilk expression) and/or childcare in the formal sector only in 10 countries: LT, BA, HR, UA, TR, AM, BE, DE, AT and FR; crèche only in TR and in IT. There are no provisions in MD, PT, MT, UK, MK, ES and GE.

According to criterion 4.5, women in the informal/ unorganized and agriculture sector are accorded the same protection as women working in the formal sector in 9 countries: LT, BA, UA, AM, BE, AT, MT,

Table 4.1:

Assessment criteria and scores for WBT*i* Indicator 4.

No.	Criteria	Score
4.1	Women covered by national legislation are allowed the following weeks of paid maternity leave: **a.** Any leave less than 14 weeks **b.** 14 to 17 weeks **c.** 18 to 25 weeks **d.** 26 weeks or more	 0.5 1 1.5 2
4.2	Women covered by national legislation are allowed at least one breastfeeding break or reduction of work hours daily. **a.** Unpaid break **b.** Paid break	 0.5 1
4.3	Legislation obliges private sector employers of women in the country to (more than one may be applicable): **a.** Give at least 14 weeks paid maternity leave **b.** Paid nursing breaks	 0.5 0.5
4.4	There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector (more than one may be applicable) **a.** Space for breastfeeding/breastmilk expression **b.** Crèche	 1 0.5
4.5	Women in informal/unorganized and agriculture sectors are (choose one): **a.** Accorded some protective measures **b.** Accorded the same protection as women working in the formal sector	 0.5 1
4.6	(more than one may be applicable) **a.** Information about maternity protection laws, regulations or policies is made available to workers **b.** There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided	 0.5 0.5
4.7	Paternity leave is granted in the public sector for at least 3 days	0.5
4.8	Paternity leave is granted in the private sector for at least 3 days	0.5
4.9	There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding	0.5
4.10	There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period	1
Total possible score		**10**

UK and ES; only some protective measures in 5 countries: HR, TR, IT, MD, PT and FR; while there are no measures in DE, MK and GE. Finally, for criteria 4.6 to 4.10, countries do well because:

- information about maternity protection laws, regulations, or policies is made available to workers in all countries, and there is a system for monitoring compliance and a way for workers to

complain if their entitlements are not provided in all countries;
- paternity leave is granted in the public and private sector for at least 3 days in all countries except for AT and MK; in GE only in the public sector;
- there is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding in all countries except GE;
- there is legislation prohibiting employment discrimination and assuring job protection for women workers during the breastfeeding period in all countries except for ES.

However, the reports remind us that over 50% of women work in vulnerable types of employment, characterized by low salary, long hours of work and informal working arrangements. With the increasing feminization of labour, countries need to strengthen maternity protection, especially for women working in the unorganized sector, and to provide support services like crèches, if rates of optimal IYCF are to increase.

Table 4.2:

The state of maternity protection in 18 European countries.

Country	Criteria										Total score
	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8	4.9	4.10	
Lithuania (LT)	2	1	1	1	1	1	0.5	0.5	0.5	1	9.5
Bosnia and Herzegovina (BA)	2	1	1	1	1	0.5	0.5	0.5	0.5	1	9
Croatia (HR)	2	1	1	1	0.5	1	0.5	0.5	0.5	1	9
Ukraine (UA)	1.5	1	1	1	1	1	0.5	0.5	0.5	1	9
Turkey (TR)	1	1	1	1.5	0.5	1	0.5	0.5	0.5	1	8.5
Armenia (AM)	1.5	1	1	1	1	0.5	0.5	0.5	0.5	1	8.5
Belgium (BE)	1	1	1	1	1	1	0.5	0.5	0.5	1	8.5
Germany (DE)	2	1	1	1	0	1	0.5	0.5	0.5	1	8.5
Italy (IT)	1.5	1	1	0.5	0.5	1	0.5	0.5	0.5	1	8
Moldova (MD)	2	1	1	0	0.5	0.5	0.5	0.5	0.5	1	7.5
Austria (AT)	1	1	1	1	1	1	0	0	0.5	1	7.5
Portugal (PT)	1.5	1	1	0	0.5	1	0.5	0.5	0.5	1	7.5
Malta (MT)	1.5	0.5	0.5	0	1	1	0.5	0.5	0.5	1	7
France (FR)	1	0.5	0.5	1	0.5	1	0.5	0.5	0.5	1	7
United Kingdom (UK)	2	0	0.5	0	1	0.5	0.5	0.5	0.5	1	6.5
North Macedonia (MK)	2	1	1	0	0	0.5	0	0	0.5	1	6
Spain (ES)	1	1	0.5	0	1	1	0.5	0.5	0.5	0	6
Georgia (GE)	1.5	1	1	0	0	0.5	0.5	0	0	1	5
Average score											7.7

Key findings

- Only seven of 18 countries provide at least 26 weeks of paid maternity leave.
- Women working in the informal/unorganised sector are poorly protected by current legislation.

Key recommendations

- Extend paid maternity leave in all European countries to a minimum of six months to enable exclusive breastfeeding as per WHO recommendations.
- Extend maternity protection to women working in the informal/unorganized sector and allocate for this adequate resources.
- Ensure that workplaces provide childcare and enable women who are breastfeeding to maintain lactation.

Best practice

After the restoration of independence from the Soviets in Lithuania, the child-raising leave (maternity leave) was extended to three years to promote the birth rate. The protection of pregnant and breastfeeding women (overtime, harmful working conditions, etc.) was foreseen in accordance with European Union directives. The Ministry of Social Protection made it a priority to protect pregnant/breastfeeding women when the country was setting up its new legal system.

5. Health and Nutrition Care Systems

Background

For a system, such as a hospital, to provide good care, it is essential that the staff are adequately trained to support mothers and their babies in optimal IYCF practices. Mothers who give birth have contact with midwives, nurses, paediatricians and general practitioners, and may have contact with other health workers, such as midwife assistants. They expect staff to provide them with accurate information and advice, communicated in a supportive and respectful way. To achieve this standard of training requires having appropriate curricula. The WBT*i* teams in the various countries therefore assessed relevant curricula/standards. These comprise undergraduate standards and curricula for all relevant specialisms and also postgraduate pre-registration training for all medical professions. The WBT*i* Assessment Tool uses an Education Checklist developed by WHO to assess if curricula/standards are adequate.[51] In addition, Continuing Professional Development (CPD) modules available in the country were taken into consideration.

As well as staff training, support depends on the institutions having suitable policies and guidelines. The extent to which these are mother-friendly (mother-centred) was also assessed.

A specific aspect of training for health workers is that they understand their responsibilities under the Code and relevant law in their country so this needs to be included in the curriculum or relevant policy.

Other health workers who may have contact with new mothers and infants also need to be suitably trained so that they do not inadvertently undermine breastfeeding. These could include pharmacists and specialists in family planning, nutrition, breast cancer, etc. and they too need access to appropriate CPD.

Key question

Do care providers in these systems undergo skills training, and do their pre-service education curricula support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and are health workers' responsibilities to the Code in place?

Criteria for assessment and scoring

Table 5.1 gives the criteria for assessment and scoring of the indicator. The seven criteria have maximum scores of 1 or 2 and the total score is calculated by adding the scores for the seven criteria. Table 5.2 shows the scores for each criterion and the total score out of a maximum of 10. The total score is colour-coded.

Findings

As shown in Table 5.2, the average score on this indicator is 6.5, ranging from 2.5, which is in the red zone (Lithuania) to the maximum possible of 10 (Turkey). The majority of the countries (ten) fall in the yellow zone and five in the blue zone.

Detailed findings

5.1 Pre-registration training for health professionals

In most European countries, there is inadequate coverage of IYCF in the training of health professionals, the exceptions being TR, GE, PT, MK and BA, making this one of the most poorly

51 WHO (2003). Infant and Young Child Feeding: a tool for assessing national practices, policies and programmes p.131. Available at: https://www.who.int/nutrition/publications/inf_assess_nnpp_eng.pdf

Criteria	Adequate	Inadequate	No reference
5.1) A review of health provider schools and pre- service education programmes for health professionals, social and community workers in the country indicates that infant and young child feeding curricula or session plans are adequate or inadequate.	2	1	0
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.	2	1	0
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.	2	1	0
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
5.5) Infant feeding and young child feeding information and skills are integrated, as appropriate, into training programmes focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)	1	0.5	0
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.	1	0.5	0
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	0.5	0

Table 5.1:

Assessment criteria and scores for WBT*i* Indicator 5.

rated criteria for Indicator 5. Turkey's National Breastfeeding Scientific Committee has been developing standardised curricula for health professionals since 2015. Germany and the United Kingdom, however, noted that there is marginal coverage for doctors and nurses but midwives receive more training. The inadequate coverage may be either in the limited range of topics or in the short time spent – in Spain, for example, there is usually a maximum of two hours for covering breastfeeding, artificial and complementary feeding.

Variation of IYCF training is a common theme as it may depend on the professional group being trained, the region of a country or the specific institution. Croatia's report mentioned that it depends on the motivation and experience of the lecturer. Even if there are initiatives to train health professionals, they may be unofficial, as in Portugal. Spain also stated that there is no official requirement to learn about breastfeeding. Italy pointed out that the practical training often occurs where support for breastfeeding is suboptimal.

Lithuania identified a clear need for defining the training requirements in order to improve quality and that there is no government policy about workforce qualifications in IYCF. The UK also

Table 5.2:

The state of health and nutrition care systems support for IYCF in 18 European countries.

Country	Criteria							Total score
	5.1	5.2	5.3	5.4	5.5	5.6	5.7	
Turkey (TR)	2	2	2	1	1	1	1	10
Georgia (GE)	2	2	2	0.5	1	1	1	9.5
Portugal (PT)	2	1	2	0.5	1	1	1	8.5
Moldova (MD)	1	2	2	0	1	1	1	8
Ukraine (UA)	1	1	2	1	1	1	1	8
Malta (MT)	1	1	2	0.5	1	1	1	7.5
Belgium (BE)	1	2	2	0.5	0.5	0	1	7
Bosnia& Herzegovina (BA)	2	1	1	0.5	1	0.5	0.5	6.5
North Macedonia (MK)	2	1	2	0.5	0.5	0	0.5	6.5
Croatia (HR)	1	1	2	0.5	0.5	0.5	0.5	6
Spain (ES)	1	2	1	0.5	0.5	0.5	0.5	6
Austria (AT)	1	1	1	0	0.5	1	1	5.5
France (FR)	1	1	2	0	0.5	0.5	0.5	5.5
United Kingdom (UK)	1	2	1	0.5	0.5	0	0.5	5.5
Armenia (AM)	1	1	1	0.5	0.5	0.5	0.5	5
Italy (IT)	1	1	1	0.5	0.5	0.5	0.5	5
Germany (DE)	1	1	1	0.5	0.5	0	0.5	4.5
Lithuania (LT)	0	0	1	0.5	0.5	0	0.5	2.5
Average score								6.5

commented that there are no training standards in infant feeding required for infant feeding coordinators.

A lack of up-to-date textbooks in relation to IYCF is mentioned by Italy and Armenia, whereas in Turkey the language barrier hinders access to important new findings, which makes updating curricula and textbooks more difficult. Spain's Ministry of Health published a clinical practice guide on breastfeeding in 2017, compiled by prestigious professionals, but there has been little dissemination due to cost and lack of interest.

5.2 Mother-friendly standards in maternity care facilities

In only a third of evaluated European countries (TR, GE, MD, BE, ES and UK) have standards and guidelines on Mother-friendly care been developed and disseminated adequately. Baby-friendly accredited maternity facilities require Mother-friendly practices so those may be the only facilities meeting Mother-friendly standards, as in Ukraine and Austria. Germany has Mother-friendly recommendations but no official guidelines.

Turkey has disseminated the Mother-friendly guidelines to all hospitals but only five currently meet the standards. Moldova, however, has an expectation that all maternity hospitals will achieve Family-friendly status.

5.3 In-service training programmes for health/nutrition care providers

In just over half of the countries there is adequate provision of in-service training in IYCF. Baby-

friendly services provide some in-service training but non-accredited services are not required to provide any. Various limitations are mentioned. There may be limited availability, as in Armenia, where there are in-service programmes in only half the country. Austria pointed out that, although there are good education programmes available, health professionals often have to pay for it themselves. In Germany such training is often provided by or sponsored by formula companies, but is still recognised by local health authorities and medical associations. North Macedonia has fairly comprehensive continuing professional development, with an annual programme funded by the Ministry of Health, but there is only one day of training and the standards require 40 hours. Where CPD is optional, there may be low take-up, as in the e-learning for GPs and paediatricians produced in the UK by the Baby Friendly Initiative.

5.4 Health worker training on the International Code and relevant national law

Only two countries (Turkey and Ukraine) rated the training of health workers on their responsibilities under the Code as adequate, making this the most poorly rated criterion of Indicator 5. In Turkey, the Code and national law are included in the 18 hr BFHI course, which is coordinated by the Turkish Public Health Agency. In Bosnia and Herzegovina there is training available but it is not available for all health workers or implemented evenly across the country. Croatia is similar, with not enough training sessions available for all health workers, mainly those in maternity facilities.

5.5, 5.6 IYCF training incorporated into other relevant training, and throughout the country

Seven of 18 countries assessed IYCF to be adequately integrated into other health training programmes and six of these (TR, GE, PT, MD, UA and MT) reported that in-service training in these is available throughout the country.

5.7 Policies provide for mothers and babies to stay together when one is hospitalised

Only eight European countries have policies which enable mothers and babies to stay together when hospitalised. They are: TR, GE, PT, MD, UA, MT, BE and AT. In most countries a parent can stay with a hospitalised child, although this is often not the case with babies admitted to neonatal units, which are therefore an anomaly. In Austria there are extra beds in many hospitals which can be moved next to the child's bed and some hospitals have special mother and child rooms. However, in Croatia there is not enough space in most facilities to ensure mothers and infants can stay together. In Moldova, there is insurance cover for parents of children under 3 years old.

Admitting an infant or young child to stay with a hospitalised mother is less common. In Germany there are a few hospitals which try to avoid separating mother and child. In Italy, infants are not admitted with their mothers and breastfeeding is likely to stop. Similarly, in Moldova, there is no framework supporting a child accompanying the mother, even if breastfeeding. In Turkey, when a mother is hospitalised for reasons not related to the birth, the healthcare provider makes the decision about the baby staying, depending on the mother's condition.

An online survey of mothers' experiences of being hospitalised in the UK found inconsistency between hospitals because of the lack of national policies, although the professional body, the Royal College of Nursing, had recommended from 2013 keeping mothers and babies together. For mothers who were with their baby, whichever of them had been hospitalised, between one third and one half felt they did not receive adequate assistance with breastfeeding.

Key findings

- In most of the European countries which carried out a WBT*i* assessment the coverage of IYCF in pre-registration training of health professionals is inadequate.
- Only half the countries have adequate provision of in-service training for health care providers.
- 16 out of the 18 countries do not provide adequate training to health workers on their responsibilities under the International Code.
- There is a lack of national guidance to enable infants and young children to stay with their hospitalised mothers where there is no medical reason for separation, and for mothers to stay with their infants in neonatal units.

Key recommendations

- Mandatory pre-registration IYCF training for health professionals working with mothers, infants and young children.
- Implement Mother-friendly standards of care in all maternity hospitals.
- Integrate the Code into pre-service and in-service training, for all health workers involved with mothers, infants and young children.
- Enable babies and young children to accompany their hospitalised mothers, and parents to stay with their babies admitted to neonatal units.

Best practice

Turkey has achieved the top score by addressing different aspects of the Indicator 5 criteria simultaneously and well. There is national leadership as the National Breastfeeding Scientific Committee has been working to develop standardised curricula for health professional training since 2015 and the Turkish Public Health Agency coordinates the 18-hour breastfeeding counselling training course under the Baby Friendly Health Institutions Programme. There are child health policies which provide the opportunity for mothers and babies to stay together when one is hospitalised. In addition, the Mother-Friendly Hospital Initiative is underway.

6. Mother Support and Community Outreach: Community-based Support for the Pregnant and Breastfeeding Mother

Background

The *Global Strategy* recognizes the need for community-based support for pregnant and breastfeeding women. Step 10 of the BFHI, as well as Step 7 of BFCI, also highlight this practice. Studies clearly demonstrate that skilled support increases breastfeeding rates. Women's feeding decisions regarding initiation of breastfeeding and exclusive breastfeeding, as well as when to start complementary foods and what is to be given, are not taken and carried out in isolation but are influenced by family, in particular the father, friends and the wider community. Thus women require accurate and timely information on IYCF to help build confidence and resolve problems if they occur, supportive and empathic care before, during and after childbirth at the community level, with active listening and practical help, to succeed in implementing optimal IYCF practices.

Outreach activities include easy availability within the community of skilled counsellors, home visits, mother support groups and other such services that enable women to feed their infants and young children in the best possible manner. It is essential that new parents receive accurate information from these various sources on how breastfeeding works, what is normal behaviour in a newborn baby, how to know if the child is getting enough milk, the importance of exclusive breastfeeding in the first 6 months, the timely introduction of adequate and appropriate complementary foods and where to obtain skilled support if needed.

Women requiring such services include those who have given birth in hospitals and have returned to the community, as well as those who have given birth at home, if any. The network of support can be provided formally and/or informally as part, in some countries, of a BFCI. It is more effective if breastfeeding support from all sources is integrated, and it is essential that clear pathways for referral exist for those mothers with more complex issues who need additional help or more specialized support.

Key question

Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding?

Criteria for assessment and scoring

Table 6.1 gives the five criteria for scoring this indicator. The scores for all criteria range from 0 to 2. The maximum a country can score is 10.

Findings

Table 6.2 provides colour coding and a graph of the score of this indicator on a scale of 10. The average score for the indicator is 6.3 (range 4-8). While no country is in the green zone, 10 countries are in the blue range, with three countries (MT, TR, UA) scoring 8 points each out of a possible ten. The remaining 8 countries are in the yellow zone (range 4-6).

Detailed Findings

A look at Table 6.2 clearly indicates that community level support for women to practice optimal IYCF practices is inadequate. In only nine European countries – BE, BA, FR, GE, LT, MT, PT, TR and UK – do all pregnant women have access to community-

Table 6.1:

Assessment criteria and scores for WBT*i* Indicator 6.

Criteria	Scoring		
	Yes	To some degree	No
6.1 All pregnant women have access to community-based ante-natal and post-natal support systems with counselling services on IYCF.	2	1	0
6.2 All women receive support for IYCF at birth for breastfeeding initiation.	2	1	0
6.3 All women have access to counselling support for IYCF counselling and support services have national coverage.	2	1	0
6.4 Community-based counselling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.	2	1	0
6.5 Community-based volunteers and health workers are trained in counselling skills for IYCF.	2	1	0
Total possible score	**10**		

Table 6.2:

The State of Mother Support and Community Outreach in 18 European Countries.

Country	Criteria					Total score
	6.1	6.2	6.3	6.4	6.5	
Malta (MT)	2	2	2	1	1	**8**
Turkey (TR)	2	2	2	1	1	**8**
Ukraine (UA)	1	2	2	2	1	**8**
Belgium (BE)	2	1	2	0	2	**7**
Croatia (HR)	1	1	2	2	1	**7**
France (FR)	2	1	2	1	1	**7**
Georgia (GE)	2	2	2	0	1	**7**
Moldova (MD)	1	2	1	2	1	**7**
Portugal (PT)	2	2	2	0	1	**7**
United Kingdom (UK)	2	1	2	1	1	**7**
Bosnia and Herzegovina (BA)	2	1	1	1	1	**6**
Armenia (AM)	1	1	1	1	1	**5**
Austria (AT)	1	1	1	1	1	**5**
Italy (IT)	1	1	1	1	1	**5**
Lithuania (LT)	2	1	1	0	1	**5**
North Macedonia (MK)	1	1	1	1	1	**5**
Spain (ES)	1	1	2	0	1	**5**
Germany (DE)	1	1	1	0	1	**4**
Average score						**6.3**

based antenatal and postnatal support systems with counselling services on IYCF. In only six countries – GE, MD, MT, PT, TR, UA - is adequate support available at birth, which is particularly important to establish timely initiation of breastfeeding. In 10 countries – BE, HR, FR, GE, MT, PT, ES, TR, UA, UK - all women have access to counselling support for IYCF, and support services have national coverage. In only 3 countries – HR, MD, UA – are community-based support services for pregnant and breastfeeding women, such as Mother Support Groups, integrated inter- and intra-sectorally into an overall infant and young child health and development strategy; BE, GE, DE, LT, PT and ES have not integrated these services to any degree. Almost all European countries do not provide adequate training on IYCF counselling skills to community workers, BE being the exception.

Key Finding

- Community-based support for women to practice optimal IYCF is inadequate in most countries, especially in regard to training of community-based volunteers and health workers in IYCF counselling skills.

Key Recommendations

- Build community outreach into IYCF policies.
- Make communities Baby-friendly by ensuring the provision of easy and universal access to skilled counselling and child-care services and monitor its coverage over time and communities.

Best Practice

In the three top-scoring countries, pregnant and breastfeeding women have free access to maternal and child care services where adequately trained health professionals counsel and support them on optimal IYCF, helping them overcome obstacles. An important role is also played by the availability of peer support and mother-to-mother support groups.

7. Information Support

Background

Appropriate, adequate and evidence-based information on nutrition, free from commercial influence, is crucial for mothers and families to make informed decisions about feeding their infants and young children. Mothers need to understand the importance of breastfeeding for their own and their baby's health, as well as understand the risks of artificial feeding. To ensure this, countries need to develop strategies for Information, Education and Communication (IEC) on IYCF, which involves all possible forms of media, as well as face-to-face counselling, and includes all sectors of society. To be effective, this needs to be coordinated by a National Breastfeeding Committee and/or Breastfeeding Coordinator.

Key question

Are comprehensive IEC strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?

Criteria for assessment and scoring

Table 7.1 gives the criteria for assessment and scoring of the indicator. The five criteria have scores ranging from 0 to 2 and the total score is calculated by adding the individual scores for a maximum score of 10.

Findings

Table 7.2 provides the country scores for each criteria and the total, colour-coded score out of a maximum of 10. The average score from 18 European countries for this indicator is 5.6. The highest score (9) was achieved by 2 countries, Malta and Turkey, which, along with Italy, Georgia and Armenia are in the blue zone, whereas the lowest score (1.5) was recorded in Lithuania, placing it and Germany in the red zone.

The majority of countries are coded yellow, with a score varying between 4 and 7. Not a single country obtained top scores for this indicator.

Detailed findings

The three criteria with the lowest scores are 7.2b – provision of group counselling, 7.5 – provision of information on the safe preparation of infant formula, and 7.3/7.1 – provision of information on the risks of formula feeding/free of commercial interests. Only seven countries (TR, MT, IT, AM, UA, HR, PT) have a clear strategy for improving IYCF that ensures all information and materials are free from commercial influence, while 11 European countries – (GE, MK, UK, MD, BA, BE, AT, ES, FR, DE, LT) – do not.

Half of the evaluated countries provide individual counselling on IYCF, whereas in the remaining countries (MT, IT, AM, MD, BA, ES, FR, DE, LT) it was found to be inadequate. In regard to group education, only five countries (TR, GE, UA, HR and AT) have national health systems that ensure this is provided fully, and the remaining countries provide this service partially; the exception is Lithuania, which does not provide this service at all.

The national assessment teams of 11 countries (IT, UA, HR, UK, PT, BE, AT, ES, FR, DE, LT) found the IYCF IEC materials to be inadequate while 7 countries (TR, MT, GE, AM, MK, MD, BA) have IYCF IEC materials which are objective, consistent and in line with the national/ international recommendations and include information on the risks of artificial feeding.

Lithuania does not have IEC programmes that include IYCF, nine countries (TR, GE, MK, UA, HR, UK, PT, AT, DE) have incorporated them to some degree and the remaining countries (MT, IT, AM, MD, BA, BE, ES, FR) have IEC programmes that include IYCF which are implemented at a local level and are free from commercial influence.

Work needs to be done on providing families with correct information about the risks of artificial

Table 7.1:

Assessment criteria and scores for WBT*i* Indicator 7.

Criteria	Scoring		
	Yes	To some degree	No
7.1 There is a national IEC strategy for improving IYCF that ensures all information and materials are free from commercial influence/ potential conflicts of interest are avoided	2	0	0
7.2a National health/nutrition systems include individual counselling on IYCF	1	0.5	0
7.2b National health/nutrition systems include group education and counselling services on IYCF	1	0.5	0
7.3 IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
7.4. IEC programmes (e.g. World Breastfeeding Week) that include IYCF are being implemented at a local level and are free from commercial influence	2	1	0
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF)	2	0	0
Total possible score	**10**		

Table 7.2:

The state of IEC in 18 European countries.

Country	Criteria						Total score
	7.1	7.2 a	7.2 b	7.3	7.4	7.5	
Turkey (TR)	2	1	1	2	1	2	**9**
Malta (MT)	2	0.5	0.5	2	2	2	**9**
Italy (IT)	2	0.5	0.5	1	2	2	**8**
Georgia (GE)	0	1	1	2	1	2	**7**
Armenia (AM)	2	0.5	0.5	2	2	0	**7**
North Macedonia (MK)	0	1	0.5	2	1	2	**6.5**
Ukraine (UA)	2	1	1	1	1	0	**6.0**
Croatia (HR)	2	1	1	1	1	0	**6.0**
United Kingdom (UK)	0	1	0.5	1	1	2	**5.5**
Portugal (PT)	2	1	0.5	1	1	0	**5.5**
Moldova (MD)	0	0.5	0.5	2	2	0	**5.0**
Bosnia & Herzegovina (BA)	0	0.5	0.5	2	2	0	**5.0**
Belgium (BE)	0	1	0.5	1	2	0	**4.5**
Austria (AT)	0	1	1	1	1	0	**4.0**
Spain (ES)	0	0.5	0.5	1	2	0	**4.0**
France (FR)	0	0.5	0.5	1	2	0	**4.0**
Germany (DE)	0	0.5	0.5	1	1	0	**3.0**
Lithuania (LT)	0	0.5	0	1	0	0	**1.5**
Average score							**5.6**

feeding. Twelve countries (AM, AT, BE, BA, HR, FR, DE, LT, MD, PT, ES, UA) either do not have or have insufficient materials and only 6 countries (TR, MT, IT, GE, MK, UK) provide materials on the risks of artificial feeding.

In the European region there is some information provided by governments or other sources (NGOs, health professionals, LLL, ELACTA), which is unbiased (Figures 7.1, 7.2, 7.3, 7.4); however, the majority is provided by commercial companies, which have a vested interest. These materials are eye-catching, available in large quantities and cover more media channels. Commercial companies with 'Baby Clubs' are very successful in reaching out to mothers, especially via internet and social media.

52

53

54

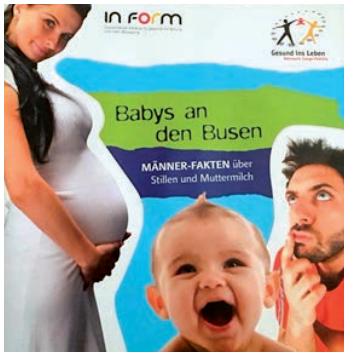


Figure 7.1, 7.2, 7.3: Good practice information support produced by Austrian and German governments.

Figure 7.4: Good practice materials produced by La Leche League International, VSLÖ (Association of Austrian Lactation Consultans) and ELACTA (European Lactation Consultant Association).

52 Healthministry Austria – Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz – Stillen ein guter Beginn

53 Germany – Gesund ins Leben, Stillen was sonst

54 Germany – Gesund ins Leben, Babys an den Busen

Key Findings

- Most European countries do not have a national IEC strategy for improving IYCF that ensures all information and materials are free from commercial influence.
- Two thirds of assessed countries do not include information on the risks of artificial feeding in IYCF IEC materials.

Key Recommendations

- All countries need a clear strategy for improving IYCF that ensures all information and materials are free from commercial influence and potential conflicts of interest.
- All parents and caregivers who choose to give their infants breast milk substitutes need information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula.

Best Practice

In the two top-scoring countries, a very diverse range of IEC activities are conducted utilising various forms of communication, including radio and television, social media, written materials and face-to-face contact. In Malta, the Health Promotion and Disease Prevention Directorate regularly communicates evidence-based messages on optimal IYCF to women of childbearing age, and organises an annual seminar to commemorate Breastfeeding Week. Despite good practice, Malta identified gaps in reaching populations with poor literacy, low socioeconomic status and poor knowledge of Maltese or English, e.g. migrant populations.

8. Infant Feeding and HIV

Background

International guidelines, as established by the British HIV Association,[55] CDC,[56] WHO,[57] and European AIDS Clinical Society,[58] describe the essential interventions necessary for the protection and support of the HIV mother and baby in order to ensure the baby remains free from HIV. Exclusive breastfeeding for six months is the ideal feeding practice, regardless of HIV status.[59]

Antiretroviral (ARV) drug use during pregnancy and breastfeeding is safe and effective in reducing mother-to-child transmission of HIV through breastfeeding and thus is of benefit in preventing child morbidity and mortality.

HIV-infected mothers who breastfeed are advised to exclusively breastfeed their infant for the first 6 months, given that breast milk offers protection against infectious diseases while preventing malnutrition. Exclusive breastfeeding is more beneficial than mixed feeding in the presence of infectious diseases, including HIV. It reduces the risk of HIV transmission by about half when ARV therapy is not available. However, ARVs given during breastfeeding can reduce the transmission of HIV to as low as one percent.

Key question

Are policies and programmes in place to ensure that HIV-positive mothers are supported to carry out the national recommended infant feeding practice?

Criteria for assessment and scoring

Table 8.1 gives the criteria for assessment and scoring of the indicator. The nine criteria have scores ranging from 0.5 to 2 and the total score is calculated by adding the scores for the nine criteria.

Findings

As shown in Table 8.2, the average score obtained for the 18 countries in the European region for this indicator is 5.3. The score ranges from a maximum of 10 for Portugal to 0 for Belgium. Six countries (UA, MD, MT, GE, AM and FR) are in the blue zone, five countries (UK, BA, IT, LT and TR) are in the yellow zone, whereas a third of the countries (HR, ES, AT, MK, DE and BE) are in the red zone for all criteria.

Detailed findings

The three criteria with the worst findings are 8.2 – Code implementation, 8.8 – countering misinformation on HIV, IYCF and promoting 6 months of exclusive breastfeeding, and 8.9 – monitoring interventions for the prevention of HIV transmission.

Of the 18 European countries, only half (PT, MD, UA, MT, GE, AM, BA, UK, IT) have a policy on IYCF and HIV in place, while four countries (FR, LT, TR, DE) meet this criterion only partially. Five countries (PT, MD, UA, GE, AM) have IYCF and HIV policies which address the Code, while four countries (MT, FR, UK, IT) include it only partially.

55 BHIVA 2018 http://www.bhivaguidelines.org/

56 CDC https://www.cdc.gov/hiv/guidelines/index.html

57 WHO: HIV and infant feeding (2010) http://www.who.int/maternal_child_adolescent/topics/newborn/nutrition/hivif/en/

58 European AIDS Clinical Society (EACS) (2017) http://www.eacsociety.org/files/guidelines_8.2-english.pdf

59 Part 1 Antiretroviral drugs and breastfeeding. World Health Organization http://www.who.int/maternal_child_adolescent/topics/child/nutrition/hivif_qa/general/q7/en/

Table 8.1:

Assessment criteria and scores for WBT*i* Indicator 8.

No.	Criteria	Score Yes / To some degree / No		
8.1	The country has a comprehensive updated policy in line with international guidelines on IYCF that includes infant feeding and HIV.	2	1	0
8.2	The infant feeding and HIV policy gives effect to the International Code/ National Legislation.	1	0.5	0
8.3	Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
8.4	HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
8.5	Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV-positive mothers.	1	0.5	0
8.6	Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	1	0.5	0
8.7	HIV-positive breastfeeding mothers, who are supported through provision of ARVs, in line with national recommendations are followed up and supported to ensure their adherence to ARVs.	1	0.5	0
8.8	Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
8.9	Ongoing monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV-negative or of unknown status.	1	0.5	0
Total possible score		**10**		

Only six of the assessed countries (PT, MD, UA, MT, GE, FR) provide training for health staff and community workers on HIV and IYCF, with another six (AM, BA, UK, IT, LT, HR) doing this only as part of the BFHI.

Eleven countries (PT, MT, GE, AM, FR, BA, UK, IT, LT, TR, AT) reported offering HIV counselling and testing routinely to couples considering pregnancy or during pregnancy, of which Moldova, Ukraine and North Macedonia offer it partially, leaving four countries who do not offer this service (HR, ES, DE, BE). Similarly, ten countries (PT, MD, UA, MT, GE, AM, FR, BA, IT, HR) provide IYCF counselling to HIV positive mothers in line with international guidelines, with three countries offering it to some degree (LT, TR, AT) and BE, MK, DE, ES and UK, not at all.

The majority, twelve countries (PT, MD, UA, MT, GE, AM, FR, IT, LT, TR, HR, ES) provide ongoing support to mothers with HIV, while four countries (BA, UK, AT, MK) offer support to some degree. According to national assessment teams, no support is offered in Belgium and Germany. Only seven countries (PT, MD, UA, GE, FR, BA, UK) reported providing support to HIV mothers while receiving ARVs, with Malta and Croatia providing partial support. The other nine countries provide no support at all.

Only Portugal and Spain were reported to make special efforts in countering misinformation on HIV and IYCF and in promoting exclusive breastfeeding for 6 months. Seven countries (MD, UA, MT, AM, BA, UK, HR) make partial efforts. Nine countries (GE, FR, IT, LT, TR, AT, DE, MK, BE) have no system in place, making this the most poorly implemented criterion. Similarly, only three countries (PT, MD, UA) have a monitoring system in place to determine the effects of interventions for preventing HIV transmission. Seven countries claim partial monitoring (MT, AM, FR, UK, LT, TR, ES), while eight countries (GE, BA, IT, HR, AT, DE, MK, BE) report no system in place.

Table 8.2:

The state of Infant feeding and HIV in 18 European countries.

Country	Criteria									Total score
Indicator 8	**8.1**	**8.2**	**8.3**	**8.4**	**8.5**	**8.6**	**8.7**	**8.8**	**8.9**	
Portugal (PT)	2	1	1	1	1	1	1	1	1	**10**
Moldova (MD)	2	1	1	0.5	1	1	1	0.5	1	**9**
Ukraine (UA)	2	1	1	0.5	1	1	1	0.5	1	**9**
Malta (MT)	2	0.5	1	1	1	1	0.5	0.5	0.5	**8**
Georgia (GE)	2	1	1	1	1	1	1	0	0	**8**
Armenia (AM)	2	1	0.5	1	1	1	0	0.5	0.5	**7.5**
France (FR)	1	0.5	1	1	1	1	1	0	0.5	**7**
Bosnia and Herzegovina (BA)	2	0	0.5	1	1	0.5	1	0.5	0	**6.5**
United Kingdom (UK)	2	0.5	0.5	1	0	0.5	1	0.5	0.5	**6.5**
Italy (IT)	2	0.5	0.5	1	1	1	0	0	0	**6**
Lithuania (LT)	1	0	0.5	1	0.5	1	0	0	0.5	**4.5**
Turkey (TR)	1	0	0	1	0.5	1	0	0	0.5	**4**
Croatia (HR)	0	0	0.5	0	1	1	0.5	0.5	0	**3.5**
Spain (ES)	0	0	0	0	0	1	0	1	0.5	**2.5**
Austria (AT)	0	0	0	1	0.5	0.5	0	0	0	**2**
Germany (DE)	1	0	0	0	0	0	0	0	0	**1**
North Macedonia (MK)	0	0	0	0.5	0	0.5	0	0	0	**1**
Belgium (BE)	0	0	0	0	0	0	0	0	0	**0**
Average score										**5.3**

Key Findings

- Only one country, Portugal, of 18 European countries assessed, has fully incorporated Infant Feeding and HIV in its IYCF policies and programmes.

Key Recommendations

- Provide accurate and updated information about the importance of exclusive breastfeeding for 6 months in the setting of HIV and counter misinformation on HIV and IYCF. Information should be evidence-based and according to international guidelines.
- A monitoring system on health outcomes of interventions to prevent HIV transmission should be established, including for those who are HIV negative and of unknown status.
- The International Code should be included as part of IYCF and HIV policies.
- Ongoing support to HIV positive mothers while receiving ARVs should be strengthened.

Best Practice

Portugal attained the top score for this indicator by using a whole community approach which includes a national programme for prevention and control of HIV infection, provision of breast milk substitutes for infants of mothers with HIV, adequate education for women of child-bearing age with HIV and setting healthcare standards in low-risk pregnancies. These various approaches lead to development and implementation of policies and programmes that determine the care infants of HIV positive mothers and those with AIDS receive.

9. Infant Feeding During Emergencies

Background

Within the countries of the European Union, the EU Civil Protection Mechanism comes into force during emergencies, such as natural disasters or other emergencies.[60] Any country in or out of Europe can call on the Mechanism for help. Civil protection departments, NGOs and other response teams provide assistance according to the requirements of the disaster situation.

In such scenarios, where the risk of death is high, optimal breastfeeding and complementary feeding practices reduce infant mortality. The cleanest, safest food for an infant, especially in disasters or emergencies, is human milk. This is the perfect nutrition for the infant and is always hygienic and at the right temperature. Breast milk is protective against diseases, especially diarrhoea and respiratory infections, which are common causes of mortality and morbidity in emergency situations. During such disasters, there is likely to be a lack of clean drinking water and sanitation facilities, making preparation of breast milk substitutes highly risky.

With global climate changes resulting in an increasing frequency of natural disasters occurring more widely, it is essential for countries to be prepared and as part of this preparation to include guidelines on IYCF. The Operational Guidance on Infant Feeding in Emergencies (OG-IFE) provides such guidance.[61]

Key question

Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies?

Criteria for assessment and scoring

Table 9.1 gives the criteria for assessment and scoring of the indicator. The five criteria have scores ranging from 0.5 to 2 and the total score is calculated by adding the scores for the five criteria.

Findings

The average score obtained for the 18 participating countries is 1.6, clearly indicating that IYCF during emergencies has not been given a priority in the European region (Table 9.2). The score ranges from a maximum of 7.5 in North Macedonia, to 0 in AM, AT, BE, FR, DE, MD, PT, ES and UK. Only North Macedonia is in the blue zone. Turkey and Bosnia and Herzegovina are in the yellow zone. Fifteen countries (GE, MT, UA, HR, IT, LT, AM, AT, BE, FR, DE, MD, PT, ES and UK) are in the red zone for all criteria.

Detailed findings

The three criteria most poorly implemented are: 9.1 – a comprehensive IYCF policy, 9.5a – inclusion of IYCF during emergencies in pre-/in-service training for relevant personnel, 9.5b – training of relevant personnel taking place as per national emergency preparedness and response plan.

North Macedonia attained a top score of 7.5 out of 10 among the 18 European countries, showing that it has addressed most of the criteria for Indicator 9. North Macedonia has taken a comprehensive approach towards a system for emergency preparedness, which includes IYCF during emergencies. This was inspired by the migrant crises, whereupon the NBC took on board this initiative.

60 EU Civil protection mechanism http://ec.europa.eu/echo/what/civil-protection/mechanism_en

61 Operational Guidance on Infant Feeding in Emergencies (OG-IFE) – ENN. Available at https://www.ennonline.net/operationalguidance-v3-2017

Croatia and Italy have addressed criterion 9.4 by ensuring resources for the implementation of the emergency preparedness and response plan. Lithuania has a comprehensive policy in place. Nine countries (AM, AT, BE, FR, DE, MD, PT, ES, UK) have not addressed any of the criteria for indicator 9. These countries should take action to put this issue on their health agenda as a priority.

Table 9.1:

Assessment criteria and scores for WBT*i* Indicator 9.

No.	Criteria	Score Yes / To some degree / No		
9.1	The country has a comprehensive policy on IYCF that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
9.2	Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding IYCF in emergency situations have been appointed	2	1	0
9.3	An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers:			
	a) basic and technical interventions to create an enabling environment for breastfeeding, including counselling by appropriately trained counsellors, support for re-lactation and wet-nursing, and protected spaces for breastfeeding;	1	0.5	0
	b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breast milk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions.	1	0.5	0
9.4	Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
9.5	**a)** Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	1	0.5	0
	b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
Total possible score		**10**		

Key Findings

- Indicator 9 is not considered a priority in the countries of the European Region.
- Not a single country has fully integrated IYCF during emergencies into pre- and in-service training for emergency management and relevant health care personnel.
- Only four countries have – to some degree – a policy on IYCF that includes emergency situations.
- Only three countries – North Macedonia, Turkey and Ukraine – organise orientation and training in IYCF during emergencies for relevant personnel.

Table 9.2:

The state of Infant feeding during Emergencies in 18 European countries

Country	Criteria							Total score
	9.1	9.2	9.3a	9.3b	9.4	9.5a	9.5b	
North Macedonia (MK)	2	2	1	1	0	0.5	1	7.5
Turkey (TR)	1	1	0.5	0	2	0.5	0.5	5.5
Bosnia and Herzegovina (BA)	1	1	0.5	0.5	1	0	0	4
Georgia (GE)	0	1	0.5	0.5	1	0	0	3
Malta (MT)	0	1	0.5	1	0	0.5	0	3
Ukraine (UA)	0	0	0.5	0.5	1	0.5	0.5	3
Croatia (HR)	0	0	0	0	1	0	0	1
Italy (IT)	0	0	0	0	1	0	0	1
Lithuania (LT)	1	0	0	0	0	0	0	1
Armenia (AM)	0	0	0	0	0	0	0	0
Austria (AT)	0	0	0	0	0	0	0	0
Belgium (BE)	0	0	0	0	0	0	0	0
France (FR)	0	0	0	0	0	0	0	0
Germany (DE)	0	0	0	0	0	0	0	0
Moldova (MD)	0	0	0	0	0	0	0	0
Portugal (PT)	0	0	0	0	0	0	0	0
Spain (ES)	0	0	0	0	0	0	0	0
United Kingdom (UK)	0	0	0	0	0	0	0	0
Average score								1.6

Key Recommendations

- European countries need to urgently develop national policies for IYCF in emergency situations, and allocate adequate funding for its implementation.
- Appropriate orientation and education on IYCF in emergencies should be integrated into pre-service and in-service training of relevant health care personnel.

Best Practice

Macedonia (MA) attained appropriate support from the health system for Indicator 9 by incorporating a national emergency preparedness and response plan on IYCF. This was achieved following earlier migrant crises whereupon the National Breastfeeding Committee together with UNICEF and the Ministry of Health took on board this initiative. The approach taken was to prepare a standard operating procedure (SOP), based on international standards, which proved to be the key factor for ensuring adequate support to mothers, infants and young children during emergencies.

10. Monitoring and Evaluation

Background

Monitoring of policy and programme implementation and their evaluation at regular intervals is essential to improve both the policy itself and its implementation. Equally, regular monitoring of optimal IYCF practices can help identify improvements and gaps as well as action that needs to be carried out to enhance IYCF practices. Therefore, monitoring and evaluation components should be built into all major IYCF activities, and collection of data on feeding practices should be integrated into national nutritional surveillance. These data should be part of the input for programme managers and key decision-makers for future planning, as well as for mid-term review.

Use of internationally agreed-upon indicators and data collection methods should be considered, in an effort to increase availability of comparable data. It is important that strategies be devised to help ensure that key decision-makers receive important evaluation results and are encouraged to use them.

Key question

Is there a monitoring and evaluation system in place to collect, analyse and use routine data in order to improve infant and young child feeding practices?

Criteria for assessment and scoring

Table 10.1 shows the five criteria for assessing countries. The maximum total score for the indicator is 10.

Findings

Table 10.2 shows the scores for the five criteria and the total score by country. The average score is 5.7. Only one country, Turkey, falls in the green zone. All the other European countries need to improve their performance, in particular the three countries in the

Criteria	Scoring		
	Yes	To some degree	No
10.1 Monitoring and evaluation components are built into major IYCF programme activities.	2	1	0
10.2 Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions.	2	1	0
10.3 Data on progress made in implementing IYCF programme activities are routinely collected at the sub national and national levels.	2	1	0
10.4 Data/Information related to IYCF programme progress are reported to key decision-makers.	2	1	0
10.5 Monitoring of key IYCF practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	2	1	0
Total possible score	**10**		

Table 10.1:
Assessment criteria and scores for WBT*i* Indicator 10.

red zone (DE, LT and ES) where there is an almost total lack of integrated monitoring and evaluation activities, at least at a national level.

Detailed findings

As far as individual criteria are concerned, the one with the best mean score is 10.4 – data on the progress of IYCF programmes are reported to decision-makers. Whether they make optimal use of the data is another matter. The other four criteria are met by most countries to some degree, meaning that something is done, but in an unsatisfactory way, with much room for improvement, especially as far as routine national information systems using standard definitions and methods are concerned. In many countries, immunization sessions could be used to gather data on IYCF. Of note is that in some countries in Eastern Europe data are collected by Ministries of Health, but also by independent surveys, such as DHS (Demographic and Health Survey) and MICS (Multiple Indicators Cluster Survey), designed to provide a larger picture of health and social problems, but including IYCF. The results from the two parallel data collection systems do not always match, due to differences in sampling and methods.

Table 10.2:

The state of Monitoring and Evaluation in 18 European countries

Country	Criteria					Total score
	10.1	10.2	10.3	10.4	10.5	
Turkey (TR)	2	2	2	2	2	10
Georgia (GE)	2	1	2	2	2	9
Portugal (PT)	2	2	2	1	2	9
Ukraine (UA)	2	2	1	2	2	9
Armenia (AM)	1	2	2	2	1	8
Croatia (HR)	1	2	2	2	1	8
Moldova (MD)	1	1	1	2	2	7
Austria (AT)	1	1	1	2	0	5
Bosnia and Herzegovina (BA)	1	1	1	1	1	5
France (FR)	1	1	1	1	1	5
Italy (IT)	1	1	1	1	1	5
North Macedonia (MK)	1	1	1	1	1	5
Malta (MT)	1	1	1	1	1	5
United Kingdom (UK)	1	1	1	1	1	5
Belgium (BE)	1	1	1	1	0	4
Germany (DE)	1	0	0	0	1	2
Lithuania (LT)	0	0	0	0	1	2
Spain (ES)	0	0	0	0	0	0
Average score						5.7

Key Findings

- In Germany, Lithuania and Spain there is an almost total lack of IYCF monitoring and evaluation activities, with some being conducted in 14 European countries. Only Turkey has fully integrated these activities into its healthcare system.

Key Recommendations

- Since this is the key to all indicators, all countries should include IYCF practice indicators in national surveys and monitor them annually, or at least every two years. These data should then be used to inform IYCF policy.

Best Practice

Since 1991 Turkey has been actively engaged in decision-making and activities aimed at improving IYCF policies and programmes, including monitoring of IYCF practices. Turkey's top score derives from longstanding dedication to IYCF and from a combination of external support (UNICEF) and internal processes enabling implementation of agreed decisions.

11. Early Initiation of Breastfeeding

Background

Babies are born with an innate ability and desire to breastfeed. When healthy newborns are placed skin-to-skin with their mother immediately after birth, and are given sufficient time, they will self-attach to the breast and commence feeding. Hence, Step 4 of the BFHI recommends placing all babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Timely initiation of breastfeeding, within an hour of birth, is critical to newborn survival and to establishing breastfeeding over the long term.

Early initiation of breastfeeding reduces the risk of neonatal mortality, both directly and indirectly: provides the infant with colostrum, which provides immunity factors, protects infants from exposure to pathogens, promotes the maturation of the intestines and immune system, and plays an important role in the development of the infant's microbiome.[62, 63] In addition, early breastfeeding, which requires skin-to-skin contact, fosters mother-to-infant bonding and reduces the risk of hypothermia.[64] It has been estimated that early initiation of breastfeeding could reduce neonatal mortality by 22%.[65]

Skin-to-skin contact immediately after birth until the end of the first breastfeed has been shown to extend the duration of breastfeeding, improve the likelihood of babies being breastfed at all in the first months of life, and may also contribute to an increase in exclusive breastfeeding.[66]

The type of birth can significantly affect when the newborn is put to the breast. Several studies show that surgical deliveries can reduce the likelihood of immediate skin-to-skin contact and the early initiation of breastfeeding.[67, 68, 69] Studies conducted in 51 countries estimated that early initiation rates among newborns born vaginally were more than twice as high as early initiation rates among newborns delivered by caesarean section.[70] These findings are concerning because immediate skin-to-skin contact and the initiation of breastfeeding are especially important for babies born by caesarean section.

Key question

What is the percentage of babies breastfed within one hour of birth?

Definition of the indicator

Proportion of children born in the last 24 months who were put to the breast within one hour of birth

Criteria for assessment

Table 11.1 shows the rating tool used for assessing Indicator 11. The maximum score is 10.

62 Begum K, Dewey KG. Impact of early initiation of exclusive breastfeeding on newborn deaths. Insight. Alive and Thrive Technical Brief No.1. Washington, DC: FHI 360, 2010

63 Victora CG et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet 2016;387:475-90

64 Smith ER, Hur, L, Chowdhury R, Sinha B, Fawzi W, Edmond KM. Delayed breastfeeding initiation and infant survival: a systematic review and meta-analysis. PLOS One 2017;12(7)

65 Edmond KM, Zandoh C, Quigley MA et al. Delayed breastfeeding initiation increases risk of neonatal mortality. Pediatrics 2006;117:380-6

66 Moore ER et al. Early skin-to-skin contact for mothers and their healthy newborn infants. Cochrane Database of Systematic Reviews, Issue 11, No, CD003519, 2016

67 Sharma IK, Byrne A. Early initiation of breastfeeding: a systematic literature review of factors and barriers in South Asia. Int Breastfeed J 2016;11:17

68 Rowe-Murray H, Fisher JR. Baby Friendly Hospital Practices: cesarean section is a persistent barrier to early initiation of breastfeeding. Birth 2002;21:124-31

69 Alzaheb Riyadh A. A review of the factors associated with the timely initiation of breastfeeding and exclusive breastfeeding in the Middle East. Clinical Medical Insights in Pediatrics, December 2017

70 UNICEF, WHO. Capture the Moment – Early initiation of breastfeeding: The best start for every newborn. New York: UNICEF; 2018

Photo by Pavel Mazmanyan

Findings

The collection of this indicator is problematic because a third of the assessed European countries do not record the time of initiation of breastfeeding and others use secondary sources, such as the number of maternity hospitals with BFHI designation (HR) or an optional registration report (PT). Interestingly, it is these two countries that have the highest scores. No data were available for six countries: AT, BE, DE, LT, MT and ES. The average rate for the remaining 12 countries is 57.2%. The rates for individual countries show wide variation, ranging from a mere 21% in North Macedonia to 84% in Portugal (Table 11.2). None of the 12 countries which have data on this indicator are in the green zone. Most countries are in the blue zone – PT, HR, UK, GE, FR, UA, MD and TR – with three countries in the yellow zone- BA, AM, IT – and one country- MK - in the red.

Table 11.1:

Rating tool for Indicator 11.

Indicator 11	Key to rating adapted from WHO tool [71]	Scores	Colour-coding
Initiation of breastfeeding (within 1 hour)	0.1-29%	3	RED
	29.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

Table 11.2:

The proportion of newborns breastfed within the first hour of life in 12 European countries

Country	Score	Data source
Portugal (PT)	84%	4th Breastfeeding Register Report, 2013
Croatia (HR)	80%	Data for this indicator not systematically collected; figure based on proportion of newborns placed skin-to-skin at birth in Baby-friendly designated facilities.
Georgia (GE)	70%	National Centre for Disease Control and Public Health (NCDC) 2014
France (FR)	66%	National Perinatal Survey, 2016 report
Ukraine (UA)	66%	Multiple Indicator Cluster Survey 2012-2013
Moldova (MD)	61%	Multiple Indicator Cluster Survey 2012
United Kingdom (UK)	60%	Infant Feeding Survey (IFS) 2010, which sampled the population of babies in the four countries of the UK
Turkey (TR)	50%	Demographic and Health Survey -2013
Bosnia & Erzegovina (BA)	42%	Multiple Indicator Cluster Survey 2011-2012
Armenia (AM)	36%	Demographic and Health Survey 2010
Italy (IT)	36%	Pregnancy, childbirth and breastfeeding, ISTAT, Rome, 2013
North Macedonia (MK)	21%	MICS survey 2011

Key Findings

- Data on early initiation of breastfeeding is not systematically collected in 8 of 18 European countries, indicating that the importance of this WHO recommendation is not appropriately recognized.

Key Recommendations

- There is an urgent need to introduce the routine monitoring of breastfeeding initiation in all countries. The enhancement of IYCF policies and programmes, especially the implementation of the Baby-friendly Hospital Initiative, is the key to improving the rate of early initiation of breastfeeding.

71 WHO (2003). Infant and young child feeding - A tool for assessing national practices, policies and programmes. Available at: http://www.who.int/nutrition/publications/infantfeeding/9241562544/en/

12. Exclusive Breastfeeding for the First Six Months

Background

According to the *Global Strategy*, infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Exclusive breastfeeding is defined as giving no other food or drink – not even water – except breast milk and medications.

Exclusively breastfed children are less susceptible to diarrhoea and pneumonia and are 14 times more likely to survive than non-breastfed children.[72] In addition, exclusive breastfeeding results in more rapid maternal weight loss after birth and delayed return of menstrual periods.[73] Studies have also shown that in areas with high HIV infection rates exclusive breastfeeding is more protective than "mixed feeding" for decreasing the risk of HIV transmission through breastmilk and increasing overall HIV-free child survival. Infants who are breastfed exclusively during the first 6 months of life are less likely to have excess weight during late infancy (>6 months of age). This can be partially explained by the fact that breastfeeding induces different hormonal responses when compared with infant formula, the latter causing a greater insulin response, which leads to fat deposition and increased adiposity. Human milk is also rich in Bifidobacteria, which have been shown to be present to a lesser extent in the gut of obese children. A study from 22 countries in the WHO European Region analysing characteristics at birth, breastfeeding practices (general and exclusive) and risk of childhood obesity, confirms the beneficial effect of breastfeeding against obesity, which was increased if children had never been breastfed or had been breastfed for a shorter period.[74] Nevertheless, adoption of exclusive breastfeeding is far from the target endorsed by the WHO Member States at the World Health Assembly of increasing the prevalence of exclusive breastfeeding in the first 6 months up to at least 50% by 2025.

Key question

What is the percentage of babies less than 6 months of age exclusively breastfed in the last 24 hours?

Definition of the indicator

Exclusive breastfeeding under 6 months: proportion of infants 0–5 months of age who are fed exclusively with breast milk.

Criteria for assessment

Table 12.1 shows the rating tool used for assessing Indicator 12. The maximum score is 10.

Findings

No data on the rate of exclusive breastfeeding for the first six months were available for two countries: Austria and Malta. The average rate for the remaining 12 countries is 23.5%. The rates for individual countries show wide variation, ranging from a mere 9.9% in France to 65% in Croatia (Table 12.2).

None of the 16 countries which have data on this indicator are in the green zone. Two countries are

72 Black R et al. Maternal and child undernutrition and overweight in low-income and middle-income countries. Lancet 2013;382:427-51

73 Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding., The Cochrane Library, 2009, Issue 4

74 Rito A et al. Characteristics at birth, breastfeeding and childhood obesity in Europe. Obes Facts 2019;12:226-43

in the blue zone – Croatia and Georgia – whereas 13 countries are in the yellow zone – IT, MD, AM, LT, TR, ES, MK, PT, UA, BE, BA, UK, DE. France is the only country in the red zone.

Similar to Indicator 11, the collection of data for this indicator is problematic, since not all countries have comparable data, due to different definitions and methodology used. For example, the rate of exclusive breastfeeding for babies 0-6 months is not routinely monitored at a national level in Croatia and hence data are based on poorly defined exclusive breastfeeding rates collected by the Croatian Institute for Public Health for infants aged 0-2 months and 3-5 months of age. Authors of the Croatian report state that their finding, therefore, is likely to be an overestimation of the true rate. The Lithuanian country report states that there is no guarantee that the data were collected in compliance with accepted WHO definitions of exclusive breastfeeding. Portugal considered data from a group of 213 children (vaccinated at 5 months) for whom food content received in the previous 24 hours was recorded.

Table 12.1:

Rating tool for Indicator 12.

Indicator 12	Key to rating adapted from WHO tool	Scores	Colour-coding
Exclusive breastfeeding (for first 6 months)	0.1-11%	3	RED
	11.1-49%	6	YELLOW
	49.1-89%	9	BLUE
	89.1-100%	10	GREEN

Table 12.2:

Proportion of infants less than 6 months of age exclusively breastfed in 16 European countries.

Country	Score	Data source
Croatia (HR)	≅ 65%	Yearbook of the Croatian Institute for Public Health (2013)
Georgia (GE)	55%	World Bank, 2009
Italy (IT)	43%	Pregnancy, childbirth and breastfeeding, ISTAT, Rome, 2013
Moldova (MD)	36%	Multiple Indicator Cluster Survey (MICS) 2012
Armenia (AM)	35%	Demographic and Health Survey (DHS) 2010
Lithuania (LT)	32%	Monitoring of Lithuanian population health, health care activities and resources/Health Statistic, 2015.
Turkey (TR)	30%	Demographic and Health Survey (DHS)-2013
Spain (ES)	28%	National Health Surveys 2012
North Macedonia (MK)	23%	Multiple Indicator Cluster Survey, UNICEF, 2011
Portugal (PT)	22%	4th Breastfeeding Register Report, 2013
Ukraine (UA)	20%	Multiple Indicator Cluster Survey (MICS) 2012-2013
Belgium (BE)	19%	WIV-ISP: p 197 results report 2014 (on children born 3 to 9 years earlier)
Bosnia & Erzegovina (BA)	18%	Multiple Indicator Cluster Survey (MICS) 2011-2012
United Kingdom (UK)	17%	Infant Feeding Survey (IFS) 2010, which sampled the population of babies in the four countries of the UK
England	18%	
Northern Ireland	17%	
Scotland	13%	
Wales	10%	
Germany (DE)	12%	Birth cohort of 2007//2008
France (FR)	10%	Salanave B, Launay C, Boudet-Berquier J, Castetbon K. Duration of breastfeeding in France (Epifane 2012-2013)

Key Findings

- Only two European countries, Croatia and Georgia, have reasonable rates of exclusive breastfeeding, of which Croatia has implemented the BFHI in all of its public maternity facilities.

Key Recommendations

- In order to achieve the WHA exclusive breastfeeding target, European policy-makers must improve IYCF policies and programmes, especially implementation of the BFHI, International Code of Marketing of Breastmilk Substitutes and provide paid maternity leave of at least 6 months duration.

13. Median Duration of Breastfeeding

Background

The *Global Strategy* recommends that all babies be breastfed for at least two years or longer, along with appropriate complementary foods after 6 months of age. The longer an infant is breastfed, the greater the protection from numerous acute and chronic diseases.[75] Breastfeeding for 12-18 months in uninfected children born to HIV-infected mothers is associated with a significant decrease in mortality extending into the second year of life.[76] This may be attributed to the high concentrations of lactoferrin, lysozyme and immunoglobulin in human milk in the second year postpartum.[77] Breastfeeding continues to be a valuable source of nutrition as well as disease protection for as long as breastfeeding continues. It is the primary source of nutrition in the first year of life and accounts for up to 40% of a child's nutritional requirements in the second year of life. The intimacy between mother and child, enabled by breastfeeding, is vital to their bonding and the child's later development. Breastfeeding into a child's second year has been shown to prevent and reduce internalizing behavioural disorders.[78] Mothers benefit from breastfeeding as well. Breastfeeding is associated with cardiovascular health benefits[79] and other non-communicable diseases (NCDs), including cancers, chronic respiratory diseases, diabetes, etc.[80] Along with lower risks of ovarian and breast cancer, mothers who breastfeed are also less likely to suffer from postpartum depression.[81] For breast cancer alone, twenty thousand deaths could be prevented per year if mothers were enabled to adhere to WHO recommendations.[82]

Key question

What is the median duration of breastfeeding (in months)?

Criteria for assessment

Table 13.1 shows the criteria used for scoring the median duration of breastfeeding in individual countries.

Findings

Table 13.2 shows the scores for Indicator 13. All the 18 WBT*i* countries are located within the red zone, either because nationally representative data on breastfeeding duration are not collected, as in AT, BE, LT and MT, or because figures are low (median duration less than 18 months). In Austria, data are collected till the age of one, making evaluation of adherence to WHO recommendations for duration of breastfeeding impossible. In Lithuania, primary health care institutions collect data on breastfeeding, but it is neither used for centralized processing nor for calculating the median duration of breastfeeding. In the remaining countries, including Belgium and Malta, breastfeeding data are not collected routinely; for example, in Croatia and North Macedonia data are based on a one-off survey conducted by their respective UNICEF Office. In all other European countries, data were

75 Victora CG, Bahl R, Barros AJD et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet 2016;387:475-90

76 Kuhn L et al. Elevations in mortality associated with weaning persist into the second year of life among uninfected children born to HIV-infected mothers. Clin Infect Dis 2010;50:437-44

77 Perrin MT, Fogleman AD, Newburg DS, Allen JC. A longitudinal study of human milk composition in the second year postpartum: implications for human milk banking. Matern Child Nutr 2017;13(1) doi: 10.1111/mcn.12239

78 Huang T et al. Infant breastfeeding and behavioural disorders in school-age children. Breastfeed Med 2019;14:115-20

79 Binh N, Kai J, Ding D. Breastfeeding and maternal cardiovascular risk factors and outcomes: a systematic review. PLoS One 2017;12(11):e0187923

80 Kelishadi R, Farajian S. The protective effects of breastfeeding on chronic non-communicable diseases in adulthood: a review of evidence. Adv Biomed Res 2014;3:3 doi: 10.4103/2277-9175.124629

81 Chowdhury R, Sinha B, Sankar MJ et al. Breastfeeding and maternal health outcomes: a systematic review and meta-analysis. Acta Paediatr 2015;104(Suppl 467):96-113

82 World Cancer Research Fund International (2018). Driving action to prevent cancer and other non-communicable diseases.

extracted from research studies, which are often not national in coverage.

The median duration of breastfeeding ranges from the lowest of three months in the UK, up to 16.5 months in Turkey. Since different breastfeeding data are collected, and most often not systematically, or studies were conducted sporadically, it is difficult to compare them, estimate the average or evaluate general trends.

However, it is clear that in none of the European countries assessed does the median duration of breastfeeding reach the recommended age of two years and in only three countries - Georgia, Moldova and North Macedonia – does it reach the age of one, with only Turkey exceeding 12 months. Interestingly, in Turkey the median duration of breastfeeding of girls and boys differs, with boys being breastfed approximately two months longer than girls.

Table 13.1:

Rating tool for Indicator 13.

Indicator 13	Key to rating adapted from WHO tool	Scores	Colour-coding
Median duration of breastfeeding	0.1-18 months	3	RED
	18.1-20 months	6	YELLOW
	20.1-22 months	9	BLUE
	22.1-24 months or beyond	10	GREEN

Table 13.2:

Median Duration of Breastfeeding in 14 European Countries.

Country	Score (months)	Source
Turkey (TR)	16.5	2013 Demographic and Health Survey, Hacettepe University, Institute of Population Studies, Ankara; Ministries of Development and Health, November, 2014
Moldova (MD)	12.3	Multiple Indicator Cluster Survey, 2012
North Macedonia (MK)	12.1	Multiple Indicator Cluster Survey, UNICEF, 2011
Georgia (GE)	12	Reproductive Health Survey, 2010)
Armenia (AM)	10.9	Demographic and Health Survey, 2010
Ukraine (UA)	9*	2014 Country Report for 8th Meeting of BFHI Coordinators
Bosnia & Herzegovina (BA)	8.8	Multiple Indicator Cluster Survey, 2011-2012
Italy (IT)	8.3	Pregnancy, delivery and breastfeeding. ISTAT, Rome, 2013
Germany (DE)	7.5	KiGGS Studies
Portugal (PT)	6	4th Report of the Register of Breastfeeding, 2013
Spain (ES)	6	National Health Survey, 2011;Breastfeeding in Figures, 2012
Croatia (HR)	5.5	N. Pećnik, editor. How Parents and Communities Care for the Youngest Children in Croatia. Zagreb: UNICEF Croatia, 2013.
France (FR)	4	ELFE 2011 and Epifane 2012 studies
United Kingdom (UK)	3	Infant Feeding Survey, 2010

*average duration of breastfeeding

Key Findings

- Women stop breastfeeding early in Europe, far earlier than the recommended two years, with an average median duration of breastfeeding, in 14 European countries, of 8.7 months.

Key Recommendations

- Systematic collection of breastfeeding data up until the age of two years, using standardised definitions and data collection methods, is mandatory if European countries are to ensure reliable data for monitoring trends, assessing the effectiveness of interventions/campaigns and planning future activities aimed at the protection, promotion and support of breastfeeding.

14. Bottle Feeding

Background

When mothers are looking for a changing room, or a place to breastfeed their baby, they are often confronted with a bottle sign (Figures 14.1 and 14.2), despite the availability of an official International Breastfeeding Symbol (Figure 14.3). Apart from being inconsiderate of breastfeeding mothers, these signs openly promote bottle feeding, directly contradicting leading public health authorities' recommendations to breastfeed. Politicians' talk about the "new fathers", usually portrayed holding a bottle (Figure 14.4) as a sign that they are willing to care for their kids, also adds to the pressure on mothers to abandon breastfeeding. Even though bottles are under the scope of the International Code for the Marketing of Breastmilk Substitutes, meaning that they should not be promoted, they are regularly distributed, free of charge, by numerous hospitals, pharmacies and primary care practices throughout Europe as part of ″goody bags″ for mums (Figure 14.55). The baby bottle seems to be part of European culture.

Unfortunately, due to effective marketing strategies, entrenched cultural practices, perceived necessity/practicality and the lack of information on the risks of bottle feeding, many European babies are fed various foods/fluids from a bottle at some stage during the first 12 months of life. A baby who is exclusively breastfed for the first six months can progress to a cup, after the introduction of solids, along with continued breastfeeding, avoiding the need for the use of a bottle.

Possible risks of bottle feeding include:

- Reluctance to breastfeed/breast refusal[83, 84]
- Decreased milk production[85]
- Premature cessation of breastfeeding, with associated risks for mother and child
- Infections due to contamination with pathogenic bacteria in powdered milk, e.g. *Salmonella*[85, 86]
- Gastrointestinal infections from unhygienic preparation[85, 86]
- Malnutrition from incorrect preparation/diluting milk[86, 87]
- Overfeeding/forced feeding and associated excess weight[88]
- Middle ear infections[89]
- Malocclusion[90, 91, 92]
- Fewer opportunities for bonding with mother or primary caregiver, given that bottle fed babies are often fed by several people[93]
- Time required for purchasing, preparing and cleaning bottles, teats and other equipment
- Costs of artificial feeding [94, 95, 96]
- Environmental burden

---

83 Zimmerman E, Thompson K. Clarifying nipple confusion. J Perinatal 2015;35:895-9

84 LLLGB 2016. Nipple confusion? La Leche League GB. www.laleche.org.uk

85 Stuebe A. The risks of not breastfeeding for mothers and infants. Rev Obstet Gynecol 2009;2(4):222-31

86 Horta BL, Victora CG. Short-term effects of breastfeeding: a systematic review of benefits of breastfeeding on diarrhoea and pneumonia mortality. Geneva, Word Health Organization, 2013

87 Losio MN, Pavoni E, Finazzi G et al. Preparation of powdered infant formula: could product's safety be improved? J Pediatr Gastroenterol Nutr 2018;67:543-6

88 Li R, Scanlon KS, May A et al. Bottle-feeding practices during early infancy and eating behaviors at 6 years of age. Pediatrics 2014;134(Suppl 1): S70-S77

89 Bowatte G, Tham R, Allen KJ et al. Breastfeeding and childhood acute otitis media: a systematic review and metaanalysis. Acta Paediatr 2015;104:85-95

90 Narbutytė I, Narbutytė A, Linkevičienė L. Relationship between breastfeeding, bottle-feeding and development of malocclusion. Stomatologija 2013 sbdmj.lsmuni.lt

91 Peres KG, Cascaes AM, Nascimento GG, Victora CG. Effect of breastfeeding on malocclusions: a systematic review and meta-analysis. Acta Paediat. 2015;104(467):54-6

92 Onyeaso CO, Isiekewe MC. Occlusal changes from primary to mixed dentitions in Nigerian children. Angle Orthod 2008;78:64-9

93 Tharner A, Luijk MP, Raat H et al. Breastfeeding and its relation to maternal sensitivity and infant attachment. J Dev Behav Pediatr 2012;33(5):396-404

94 Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK. Why invest, and what it will take to improve breastfeeding practices? Lancet 2016;387(10017):491-504

95 UNICEF. Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK https://www.unicef.org.uk/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources.pdf

96 Bartick M, Reinhold A. The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis. Pediatrics 2010;125(5):e1048-56

Key question

What percentage of breastfed babies, 0-12 months of age, are fed with any foods or drinks (even breastmilk) from bottles? Table 14.1 shows the rating tool used for assessing Indicator 14.

Figure 14.1: Nursing compartment in Austrian train

Findings

Table 14.2 shows the percentage of breastfed infants ever fed from a bottle among nine European countries. Data for this indicator was not available for nine countries (AT, BE, GE, DE, IT, LT, MT, UT, HR), with five countries (BA, FR, MK, ES, UK) using indirect data to provide an estimate. The average rate of bottle feeding for the remaining four countries (AM, MD, PT, TR) is 57.5%, placing Europe within the red zone.

Figure 14.2: Mothers' room in Austrian shopping mall

Figure 14.3: International Breastfeeding Symbol – no copyright

Figure 14.4: 'Goody' bag, City of Vienna.

Figure 14.5: Family journal of Upper Austrian State Government, depicting the "new father"

Indicator 14	Key to rating adapted from WHO tool	Scores	Colour-coding
Bottle Feeding (0-12 months)	29.1-100%	3	RED
	4.1-29%	6	YELLOW
	2.1-4%	9	BLUE
	0.1-2%	10	GREEN

Table 14.1:

Criteria and scoring for WBT*i* Indicator 14.

Country	Score	Data source
Armenia (AM)	42%	Armenia (AM)
Moldova (MD)	47%	Demographic and Health Survey, 2005
Turkey (TR)	63%	2013 Demographic and health Survey, Hacettepe University Institute of Population Studies, Ankara, with the contributions of Ministry of Development and Ministry of Health, November 2014
Spain (ES)	≅ 72%	National Health Survey 2011/2012 (published on March 14, 2013), of the National Institute of Statistics
Portugal (PT)	78%	Direcção-Geral da Saúde e Mama Mater – IV Relatório do Registo do Aleitamento Materno, 2013
North Macedonia (MK)	≅ 79%	Multiple Indicator Cluster Survey, UNICEF, 2011
France (FR)	≅ 80%	1. Salanave B, et al. Alimentation des nourrissons pendant leur première année de vie. Résultats de l'étude Epifane 2012-2013. Institut de Veille Sanitaire; 2016. 58 p. http:/www.invs.sante.fr
Bosnia & Erzegovina (BA)	≅ 80%	Multiple Indicator Cluster Surevey 2011-2012, http://www.unicef.org/bih/media_21363.html
United Kingdom (UK)	≅ 88%	UK 2011 Diet and Nutrition Survey

Table 14.2:

The proportion of breastfed infants bottle fed in nine European countries.

Key Findings

- Bottle feeding is a prevalent practice in Europe, despite its inherent risks.

Key Recommendations

- Greater awareness, both among the medical profession and public, needs to be created about the risks of bottle feeding. Images and messages related to infant feeding need to promote breastfeeding. Governments should implement the International Code of Marketing of Breastmilk Substitutes fully. All sectors of society should support breastfeeding dyads to minimise the need for bottle feeding.

15. Complementary Feeding

Background

WHO recommends infants start receiving complementary foods (any food other than breast milk or formula) at 6 months of age, in addition to breast milk; initially 2-3 times a day between 6-8 months, increasing to 3-4 times daily after 9 months, with additional nutritious snacks offered 1-2 times per day, as desired, after 12 months of age. Foods should be prepared and given in a safe manner, with measures taken to minimize the risk of contamination and to ensure food is of an appropriate size and consistency, provided in a relaxed, supervised setting. Infants usually show signs of readiness for complementary foods; these include being able to sit upright on their own, eye-hand coordination and being willing to explore objects in their mouth. It is rare for these signs to appear together before 6 months of age. Timely introduction of complementary foods, between 6-8 months, enables exclusive breastfeeding for the first 6 months and adequate nutrition to satisfy the needs of the growing infant after 6 months of age.

Key question

Percentage of breastfed babies receiving complementary foods at 6-9 months of age? Table 15.1 shows the rating tool used for assessing Indicator 15.

Findings

There are large differences reported in the proportion of infants receiving complementary foods between 6 and 9 months in Europe (Table 15.2), probably due to the different interpretation of the 'Key question' by national assessment teams, with some countries providing data on the proportion of infants receiving complementary foods for the *first time* between 6 and 9 months (i.e. the *introduction* of complementary foods), whereas others reported the proportion of infants receiving complementary foods between 6 and 9 months, regardless of when they were introduced (i.e. the *consumption* of complementary foods). This confusion in the use of the WBT*i* tool will need to be clarified for future assessments. Given the greater tendency towards overnutrition, rather than undernutrition among children in Europe, the monitoring of the *introduction* of solids may be more appropriate for the European region.

No official data were available for AT, BE, DE, HR, LT, MT and UA. In Italy, the value of this indicator was calculated upon request, given that it is not systematically collected, whereas, in Croatia, an estimate of the proportion of infants receiving complementary foods for the first time between 6-9 months was calculated based on 6-month exclusive breastfeeding rates.

The largest proportion of infants who were receiving complementary foods at the age of 6-8 months was found in Portugal (100%), while the smallest was in North Macedonia (28%). In Portugal, about 95% of children are introduced to food diversification in the first six months, regardless of whether or not they are breastfed. In Spain, 97% of breastfed children start complementary feeding at six months, with the remaining babies receiving complementary foods between 6 and 9 months.

A high rate (79.8%) of babies given complementary foods between 6-9 months of age is reported in Turkey. After the sixth month until the 16th month, more than half of babies are both breastfed and given complementary foods. After the 16th month, breastfeeding starts to decrease, reaching 14% at 24 months of age.

According to the WBT*i* UK report, 94% of UK mothers had introduced solids by 6 months, but 75% had already introduced them by 5 months and by 9 months 99% of children were receiving complementary food. According to the Diet and Nutrition Survey of 2011, 74% of babies aged 5 months or younger had been offered solids, and the mean age of introduction was 4.7 months, despite the UK leaflet 'Introducing Solid Foods' clearly recommending solids be introduced at 6 months.

The Lithuanian Paediatric Association promotes the advice of the European Society for Paediatric

Indicator 15	Key to rating adapted from WHO tool	Scores	Colour-coding
Complementary Feeding (6-8 months	0.1-59%	3	RED
	59.1-79%	6	YELLOW
	79.1-94%	9	BLUE
	94.1-100%	10	GREEN

Table 15.1:

Criteria and scoring for WBT*i* Indicator 15.

Country	Score	Data source
Portugal (PT)	100%	Directorate-General for Health - Healthy Eating in numbers – 2014
United Kingdom (UK)	98%	Infant Feeding Survey, 2010
Spain (ES)	97%	Professional position of the AEPap (Asociación Española de Pediatría de Atención Primaria - Spanish Association of Primary Care Pediatrics) and PrevInfad feeding documents: exclusive breastfeeding for 6 months. Incorporation of solids from the 6th month
France (FR)	88%	Salanave B, de Launay C, Boudet-Berquier J, Guerrisi C, Castetbon K. Infant feeding during their first year of life. Results of the study Epifane 2012-2013. Institute of Health Monitoring, 2016
Turkey (TR)	80%	2013 Demographic and Health Survey, Hacettepe University Institute of Population Studies, with the contributions of Ministry of Development and Ministry of Health, November 2014
Italy (IT)	73%	Pregnancy, delivery and breastfeeding. ISTAT, Rome, 2013
Bosnia and Herzegovina (BA)	71%	Multiple Indicator Cluster Survey, 2011-2012
Moldova (MD)	55%	Multiple Indicator Cluster Survey, 2012; Demographic and Health Survey, 2005
Armenia (AM)	53%	Demographic and Health Survey, 2010
Georgia (GE)	35%	State Department of Statistics (SDS), National Centre for Disease Control (NCDC) and UNICEF. Georgia; Multiple Indicator Cluster Survey 2005. SDS, NCDC and UNICEF, 2008
North Macedonia (MK)	28%	Multiple Indicator Cluster Survey, UNICEF, 2011

Table 15.2:

Percentage of breastfed babies receiving complementary foods at 6-9 months of age in 11 European countries.

Data not available for Austria (AT), Belgium (BE), Croatia (HR), Germany (DE), Lithuania (LT), Malta (MT) and Ukraine (UA)

Gastroenterology, Hepatology and Nutrition, i.e. to start complementary feeding from the age of 4 months,[97] even though the official State recommendations are in line with the WHO. This is the situation in many other European countries, resulting in confusion among health professionals and parents, and subsequent low 6-month exclusive breastfeeding rates.

97 Complementary Feeding: A Position Paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition. J Pediatr Gastroenterol Nurt 2017;64(1):119-32

In Armenia, where 53% of babies receive complementary food at the age of 6 months, the most common complementary foods reported were made from grains (79%); roots and tubers (69%); cheese, yogurt, or another milk product (68%); and fruits and vegetables other than those rich in vitamin A (58%). As mentioned in their report, among breastfed children of 6 months of age and younger, 19% received complementary foods. Consumption of complementary foods is generally higher among non-breastfeeding children than breastfed.

The complex data from France demonstrate the large differences between the timing of complementary feeding within the country. The median age at which mothers started complementary feeding was 152 days, i.e. after 5 months. The minimum age of starting solids was 7 days and the maximum age was 305 days. Prior to 4 months, 12.6% of mothers had already started diversification. Of those, 53.4% started with infant cereals, 31.5% with fruit and 30.4% with vegetables. Introduction of solids between 4 and 6 months occurred in 54.3% of children and after 6 months 33.2%. The median age of introduction of solid foods was related to breastfeeding duration. For mothers having breastfed less than 28 days and for breastfeeding duration between 1 and 4 months, it was equal to the median age of diversification of the general population (152.5 days). Introduction of solid foods was, however, earlier for children who were never breastfed (136 days), and later for children breastfed at least 4 months (166.5 days).

In North Macedonia, only 30.2% of breastfed children aged 6-23 months receive solid food at least 2-3 times per day. This proportion of complementary-fed babies was higher among males (38%) and in urban areas. Among non-breastfed children, 86 % received solid, semisolid or soft food or milk four or more times per day.

Key Findings

Official data about complementary feeding of infants is missing in many European countries. However, everyday practice suggests that most European babies are receiving appropriate complementary foods between 6-9 months of age. Of greater concern is the tendency to introduce complementary foods before 6 months. This is reported to be a direct result of ESPHGAN recommendations, leading to confusion among European health providers and parents, and subsequent low 6-month exclusive breastfeeding rates.

Key Recommendations

Governments in their Nutrition policies should ensure that all infants and young children receive appropriate and adequate complementary foods between 6-9 months of age and promote the practice of exclusive breastfeeding for 6 months. Official statistics must be collected on the timing of complementary feeding, in order to monitor the situation and apply active intervention measures.

Photo by Paul Carter / wdiip.co.uk

WBT*i* Works! Impact WBT*i* has generated

When policy and programmes to support women are strengthened, improvement in breastfeeding and appropriate complementary feeding practices follows. That is the hallmark of the World Breastfeeding Trends Initiative (WBT*i*); it serves as a means to generate action towards this goal. Two examples given below demonstrate this.

An analysis of 84 countries involved in WBT*i* revealed that 35 countries studied the progress they made during this process by conducting repeat assessments between 2005 and 2016.[98] These included seven countries from the South Asia region that conducted at least three assessments each, and 28 countries that conducted two assessments. The findings show a substantial increase in average scores for policy/programme indicators, with a 14-point rise - from 50 to 64 out of 100. Afghanistan, Bangladesh, Dominican Republic and Indonesia even doubled their scores. The 35 country report also shows an average gain in breastfeeding initiation, from 46 to 51%. Exclusive breastfeeding rates remained the same, although given the time it takes to establish processes, we anticipate that comprehensive implementation of several policies will affect the rise in exclusive breastfeeding over time.

In Gambia, as a result of the WBT*i*, several key changes in government policy have occurred. According to Gambia's programme manager for the National Nutrition Agency *"The "WBTi helped make headway in the area of policy implementation. Strong advocacy led to incorporation of infant and young child feeding during the development of national policies. The National Nutrition Agency was established and a programme officer identified and made responsible for overseeing the implementation of IYCF."* The Gambian story demonstrates how WBT*i* impacts processes.

Similar experiences are happening in Europe as a results of the introduction of WBT*i*.

- In Croatia, findings from the WBT*i* report for Croatia and subsequent 'Call to Action' formed the basis for the 'National Breastfeeding Programme for the Protection and Promotion of Breastfeeding', ratified by the Croatian government in August, 2018.
- In Malta, presentation of the WBT*i* report to the Director General/Superintendent of Public Health led to breastfeeding research for identifying attitudes and knowledge needed to support IYCF being prioritised.
- In Italy, the report was presented at a meeting in which all the institutions and organizations active in the protection, promotion and support of IYCF were invited. A delegate of the Ministry of Health did attend the meeting and subsequently briefed the Minister.
- In Germany, a discussion on the International Code evolved as a direct result of WBT*i* assesssment.
- In the UK, including the devolved nations of England, Scotland, Wales, and Northern Ireland, government commitments have now been made to improve breastfeeding policies and programmes. Several health professional councils are now looking at improving pre-registration standards on infant feeding. A Parliamentary forum has been held to explore planning for infant feeding in emergencies.

98 Gupta A, Suri S, Dadhich JP et al. The World Breastfeeding Trends Initiative: Implementation of the Global Strategy for Infant and Young Child Feeding in 84 countries. J Public Health Pol 2019;40:35-65

Conclusion

The WBT*i* has been shown to improve policies and programmes. In our report, 18 European countries seem to be doing relatively well only on maternity protection (Indicator 4). However, they are letting their babies down on infant feeding during emergencies, and they do not score well for most other indicators, including full implementation of the International Code and subsequent relevant WHA resolutions, which is a basic protective measure for breastfeeding, and timely complementary feeding (Table 16). Current legislation, in most European countries, covers only infant formula for use to six months, but allows widespread marketing for follow-on and toddler formula, and no restrictions at all on the marketing of feeding bottles and teats. This situation allows manufacturers to circumvent the International Code and to keep sponsoring educational events for health professionals. The key problem, underlying all others, is the lack of proper policies, programmes and coordination. Even more serious is the fact that only three countries have a budget allocated for implementing IYCF policies and plans and less than a third have a National Breastfeeding Committee. There is therefore an urgent need for governments and policy-makers, the main target audience of this report, to develop or update comprehensive, cross-sectoral, multi-level IYCF policies and plans, ensure an adequate budget for their implementation and monitor progress. In addition, governments need to appoint a conflict of interest-free national committee and a competent and dedicated coordinator with sufficient authority to oversee the implementation of the plan. These can enable the Global Strategy to be successfully implemented and children's rights to the best possible start in life to be respected. As stated in the Global Strategy, ″Success …rests first and foremost on achieving political commitment at the highest level and assembling the indispensable human and financial resources″.

Table 16: **Country scores on policy and programme indicators**

Country	Ind 1	Ind 2	Ind 3	Ind 4	Ind 5	Ind 6	Ind 7	Ind 8	Ind 9	Ind 10	Total score (out of 100)
Turkey	10	10	5	8.5	10	8	9	4	5.5	10	80
Ukraine	9.5	8.5	4	9	8	8	6	9	3	9	74
Croatia	9.5	9.5	6	9	6	7	6	3.5	1	8	65.5
Malta	8	1	9	7	7.5	8	9	8	3	5	65.5
Georgia	4	4	7.5	5	9.5	7	7	8	3	9	64
Portugal	0	7	6	7.5	8.5	7	5.5	10	0	9	60.5
Bosnia & Herzegovina	3	8.5	6.5	9	6.5	6	5	6.5	4	5	60
Armenia	4	3.5	8.5	8.5	5	5	7	7.5	0	8	57
Moldova	5	3	5	7.5	8	7	5	9	0	7	56.5
Italy	2	6	6	8	5	5	8	6	1	5	52
United Kingdom	1	7.5	6	6.5	5.5	7	5.5	6.5	0	5	50.5
North Macedonia	6	1	6	6	6.5	5	6.5	1	7.5	5	50.5
Belgium	4	6.5	6.5	8.5	7	7	4.5	0	0	4	48
France	2	5	5	7	5.5	7	4	7	0	5	47.5
Austria	0.5	5.5	5	7.5	5.5	5	4	2	0	5	40
Lithuania	2	5	6.5	9.5	2.5	5	1.5	4.5	1	1	38.5
Spain	0	6.5	5	6	6	5	4	2.5	0	0	35
Germany	1	5.5	4	8.5	4.5	4	3.0	1	0	2	33.5

European partners involved in WBT*i*

ARMENIA

1. Maternal and Child Health Department at MoH of RA
2. Department of Paediatrics N 1 of YSMU
3. MCH Alliance of Armenia (a network of 47 NGOs, concerned with maternal and child health issues, including “Confidence” Health NGO- Member of IBFAN)

AUSTRIA

4. Austrian Association of Breastfeeding and Lactation Consultants VSLÖ
5. Austrian Agency for Health and Food Safety Ltd – AGES
6. BFHI, Health Austria, Ltd BFHI, Gesundheit Österreich GmbH
7. Austrian Midwives Committee
8. European Institute for Breastfeeding and Lactation (EISL)
9. Federal Ministry for Labour, Social Affairs, Health and Consumer Protection in Austria
10. La Leche League Österreich
11. Working Group “Young Children, Breastfeeding Mothers and Pregnant Women”

BELGIUM

12. Federal Belgium Breastfeeding Committee

BOSNIA AND HERZEGOVINA

13. Breastfeeding Advancement Group – IBFAN
14. NGO Association for support and education women “Magna”
15. AKAZ-Agency for health care quality and accreditation in the Federation of Bosnia and Herzegovina
16. Institute of Public Health of Federation of Bosnia and Herzegovina
17. Republic of Srpska, Public Health Institute
18. Ministry of Health and Social Welfare of Republic of Srpska
19. Ministry of Health of Federation of Bosnia and Herzegovina
20. UNICEF Office for Bosnia and Herzegovina
21. Institute of Public Health of Canton Sarajevo
22. Health Center “Omer Maslić” Sarajevo
23. Health Center Brčko
24. Faculty of Medicine, University of Sarajevo
25. Faculty of Medicine, University of Mostar
26. Faculty of Medicine, University of Banja Luka
27. Faculty of Health Studies, University of Sarajevo
28. Public Institution Secondary Medical School Sarajevo
29. Secondary Medical School Mostar
30. Public Institution” Agriculture and Secondary Medical School Brčko”

CROATIA

31. Ministry of Health of the Republic of Croatia
32. Ministry of Social Policies and Youth

33. UNICEF Office for Croatia
34. Croatian Public Health Institute
35. School of Public Health, Split-Dalmatia County
36. Croatian Paediatric Society
37. Croatian Society for Paediatric Gastroenterology, Hepatology and Nutrition
38. Croatian Paediatric Nurses' Society
39. Community Nurses' Society
40. Croatian Association of Breastfeeding Support Groups
41. Croatian Association of Lactation Consultants
42. NGO 'RODA' - Parents in Action

FRANCE

43. ACLP Association of Lactation consultants IBCLC who are medical health care professionals
44. ADLF Association of Milkbanks France
45. ANPDE Association of children perinatal health care professionals
46. AFCL Association of Lactation consultants IBCLC
47. BPNI Breastfeeding Promotion Network of Inida
48. CNSF National Academy of midwives
49. CoFAM Franche Coordination for Breastfeeding Actions
50. FFRSP French Federation of Perinatal Health Networks
51. IBFAN International Baby Food Action Network
52. IPA Information for Breastfeeding
53. LLL La Leche League France
54. Seinbiose Association of breastfeeding support to mothers
55. UNSSF National Union of midwives

GEORGIA

56. Ministry of Labour, Health and Social Affairs
57. International Baby Food Action Network (IBFAN)-1998 Right Livelihood Award
Recipient – Georgian group – Pediatricians & amp; Family Physicians Association "CLARITAS XXI"

GERMANY

58. DAIS Deutsches Ausbildungsinstitut für Stillbegleitung (German Institute for Training in Breastfeeding Counselling)
59. BFHI Baby-Friendly Hospital Initiative Germany
60. NBC National Breastfeeding Committee
61. ABM Academy of Breastfeeding Medicine Europe
62. RKI Robert Koch Institute
63. AFS Arbeitsgemeinschaft Freier Stillgruppen Germany (Working group of free breastfeeding support groups)
64. Klinikum Nuernberg (Nuremberg hospital)
65. AGB Aktionsgruppe Babynahrung (Baby food action group)
66. Ausbildungszentrum Laktation und Stillen (Institute for Lactation Education and Family Centered Neonatal Staff Development.)

ITALY

67. ACP – Associazione Culturale Pediatri (Cultural Association of Paediatricians)
68. AICPAM – Associazione Italiana Consulenti Professionali in Allattamento Materno (Italian Lactation Consultants Associations)
69. La Leche League Italy
70. MAMI – Movimento Allattamento Materno Italiano (Italian Movement for Breastfeeding)
71. IL MELOGRANO Centri Informazione Maternità e Nascita (Information centre for maternity and birth)
72. MIPPE – Movimento Italiano Psicologia Perinatale (Italian Movement on Perinatal Psychology)
73. Creattivamente ostetriche (Creative and cre-active midwives)
74. GIFA – Geneva Infant Feeding Association

75. Scuola Universitaria Superiore Sant'Anna, Pisa (St Anne's University High School)
76. Save the Children Italy
77. Italian Committee for UNICEF
78. UPPA – Un Pediatra Per Amico (A Paediatrician for Friend)
79. Ministero della Salute, Tavolo tecnico operativo interdisciplinare per la promozione dell'allattamento al seno (TAS) (Ministry of Health, Operational technical inter-disciplinary table for the promotion of breastfeeding)

LITHUANIA

80. Lithuanian Lactation and Breastfeeding Consultants' Association
81. Child Health Information Centre
82. Association of Local Authorities in Lithuania

MACEDONIA

83. Macedonian Ministry of Health: National Breastfeeding Committee
84. UNICEF Office –Skopje
85. Institute of Public Health
86. Health Centre Skopje- Institute for mother and child health
87. State Statistical Office
88. University St Cyril & Methodius -Medical faculty
89. Neonatology Association of Macedonia

MOLDOVA

90. Ministry of Health, Labour and Social Protection
91. Mother and Child Institute
92. State Medical and Pharmaceutical University "Nicolae Testemitanu"
93. Hospital no 1, Chisinau municipality
94. National Centre of Health Management
95. Dermatological and Communicable Diseases Hospital, Chisinau municipality
96. UNICEF Office for Moldova

MALTA

97. Superintendence of Public Health
98. Health Promotion and Disease Prevention Directorate
99. Paediatric Department: Mater Dei Hospital
100. Chief Medical Officer
101. HIV infant specialist: Mater Dei Hospital
102. HIV adult specialist: Mater Dei Hospital
103. Breast Feeding Walk in clinic: Mater Dei Hospital

PORTUGAL (not available)

SPAIN

104. BFI-Spain
105. Amamanta (Mother to Mother BF Support group)
106. Spanish Association of Primary Care Pediatrics
107. APILAM-Association for Breastfeeding Promotion, and Scientific and Cultural Investigation
108. Asociación Española de Matronas: Spanish Association of Midwives
109. Asociación Catalana Pro Lactancia Materna: Catalan Breastfeeding Association
110. Spanish Department of Health, Welfare and Equity
111. La Liga de la Leche Andalucía
112. Spanish Federation of pro-breastfeeding associations
113. Spanish Association of Pediatrics

TURKEY

114. Ankara üniversitesi, Saglik Bilimleri Fakültesi, Ebelik Bölümü (Ankara University, Faculty of health Sciences, Department of Midwifery)

115. Hacettepe Üniversitesi Tıp Fakültesi Çocuk Sağlığı ve Hastalıkları Anabilim Dalı Sosyal Pediatri Ünitesi (Hacettepe University, Faculty of Medicine, Department of Child Health and Diseases, Social Pediatrics Unit)

116. La Leche League Türkiye/La Leche League Turkey

117. Temas Emzirme ve Anne Sütü Gönülleri Dernegi (Temas, Breastfeeding and Breast Milk Volunteers Non-Profit Organization)

118. Türkiye Halk Sağlığı Kurumu Çocuk ve Ergen Sağlığı Daire Başkanlığı, Sağlığı Bakanlığı (Ministry of Health, Public Health Institution, Institute of public health, Child and Adolescent Direction)

UKRAINE

119. Ukraine Ministry of Health

120. WHO

121. UNICEF

122. National Medical Academy of Postgraduate Education named after PL Shupyk

123. Center for Global Health/CDC

UNITED KINGDOM

Core group

124. Association of Breastfeeding Mothers

125. Baby Feeding Law Group

126. Baby Milk Action

127. Best Beginnings

128. Breastfeeding Network

129. Child and Maternal Health Observatory

130. UK Department of Health

131. First Steps Nutrition Trust

132. Institute of Health Visiting

133. Lactation Consultants of Great Britain

134. La Leche League Great Britain

135. Maternity Action

136. National Infant Feeding Network

137. NCT

138. Northern Ireland Regional Breastfeeding Lead

139. Public Health England

140. Scotland Maternal and Infant Nutrition Coordinator

141. Unicef UK Baby Friendly Initiative

Additional organisations consulted

142. British Dietetic Association

143. UK Cabinet Office

144. UK Department of Health

145. General Medical Council

146. General Pharmaceutical Council

147. Nursing and Midwifery Council

148. Public Health Agency Northern Ireland

149. Public Health Scotland

150. Public Health Wales

151. Royal College of General Practitioners

152. Royal College of Midwives

153. Royal College of Paediatrics and Child Health

154. Royal College of Obstetricians and Gynaecologists

155. Unite, the Union of Community Practitioners and Health Visitors Association

156. United Kingdom Standing Conference on Specialist Community Public Health Nurse Education

About IBFAN[99]

The International Baby Food Action Network (IBFAN) was founded in 1979. It is a network of more than 273 public interest groups in 168 countries working together to bring lasting changes in infant feeding policies and practices at all levels. IBFAN aims to promote the health and wellbeing of children and their mothers, through protection, promotion and support of optimal breastfeeding and infant and young child feeding practices. IBFAN works towards universal and full implementation of the *'International Code of Marketing of Breastmilk Substitutes' (the Code)*, subsequent relevant World Health Assembly (WHA) resolutions and the *'Global Strategy for Infant and Young Child Feeding'*. IBFAN is organised into eight regional offices (Africa, Arab World, Europe, Oceania, Afrique, Asia, Latin America and Caribbean, North America) that create an international network of collaborators, most of whom are volunteers.

IBFAN was the recipient of the *Right Livelihood Award* in 1998 – considered the alternative Nobel Prize – ″for its committed and effective campaigning in support of breastfeeding″.

IBFAN's seven working principles:

1. Infants and young children, everywhere, have the right to the highest attainable standard of health.
2. Families, and in particular women and children, have the right to access adequate and nutritious food and sufficient and affordable water.
3. Women have the right to breastfeed and to make informed decisions about infant and young child feeding.
4. Women have the right to full support to breastfeed for two years or more and to exclusively breastfeed for the first six months.
5. All people have the right to access quality health care services and information free of commercial influence.
6. Health workers and consumers have the right to be protected from commercial influence which may distort their judgement and decisions.
7. People have the right to advocate for change which protects, promotes and supports basic health, in international solidarity.

99 Source: http://www.ibfan.org/

IBFAN
defending breastfeeding

WBTi
World Breastfeeding Trends Initiative (WBTi)

unicef
for every child

Ministry
of Health

IBFAN's World Breastfeeding Trends Initiative is a collaborative process to monitor
the implementation of the Global Strategy for Infant and Young Child Feeding and to generate action.
worldbreastfeedingtrends.org